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ABSTRACT

Focusing on problems believed to pose the greatest risk to the children of New Jersey, this report sets forth the views of the Governor's Committee on Children's Services Planning on priorities for action. After an executive summary of the report, the issues identified by the committee are summarized in chapter II, which describes the current status and needs of New Jersey's children and families. Issues chosen as priorities for action are detailed. Chapter III deals with actions to assure basic foundations for life and specifically addresses the issues of meeting the need for adequate income supports through AFDC, housing needs, preventive and remedial health care for children, and meeting educational needs. Chapter IV concerns actions to improve preventive and supportive services for children and families, including the social services system, comprehensive early childhood development program, and child care. Chapter V focuses on actions to address physical, emotional, and behavioral disorders, involving early intervention and mental health services, specialized services for emotionally disturbed juvenile offenders, prevention and treatment of substance abuse, and the juvenile justice system and the family court. Chapter VI briefly reports the recommendation to establish a continuous process for identifying and meeting children's needs. (RH)

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ACTION PLAN FOR CHILDREN

RECOMMENDATIONS
OF
THE GOVERNOR'S COMMITTEE
ON
CHILDREN'S SERVICES PLANNING

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NEW JERSEY'S

ACTION PLAN
FOR
CHILDREN

RECOMMENDATIONS
OF

THE GOVERNOR'S COMMITTEE
ON
CHILDREN'S SERVICES PLANNING

PREPARED BY
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Trenton, New Jersey
1985

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The Honorable Thomas H. Kean
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Dear Governor Kean:

We are pleased to transmit to you the report of your Committee on Children's Services Planning, *New Jersey's Action Plan for Children*. In accordance with the mandate of your Executive Order 35, this report sets forth the Committee's findings regarding priority needs of New Jersey's children and the Committee's recommendations for actions to meet your goal of providing our children with "the opportunity to develop to their fullest potential."

To prepare this *Action Plan*, the Committee drew upon the expertise of more than one hundred individuals, including representatives of state and county government, community groups and private agencies serving children. The process was greatly enhanced by the tremendous support and cooperation provided by the Commissioners and staff of the eight state departments represented on the Committee. Further, each recommendation incorporates the suggestions of the people on the front line—those who administer and provide services for children.

Although representatives of many diverse groups participated in the work of the Committee, a high degree of consensus emerged on the need for bold actions set forth in this plan to meet children's needs. Because the many different people involved in the process left aside individual organizational concerns, the Committee was able to develop its recommendations from a neutral framework based upon the best interest of the children of our state.

Together we present to you a plan to build upon the many new initiatives your administration has mounted on behalf of New Jersey's children. Implementation of this plan of action will require an investment of state funds and the establishment of an on-going mechanism in state government to oversee the process. Most importantly your continued strong leadership on behalf of children will be needed.

I have enjoyed chairing a committee composed of talented and dedicated members who have all given generously of their time and expertise. We have been fortunate as well to have the benefit of the skilled assistance of Ciro A. Scalera, Esq., who as Vice Chairperson has done much to facilitate the work of the Committee.

On behalf of the Committee, I wish to thank you for your strong support of the Committee and the opportunity to serve the state in this role. You have our continued commitment to serve in accordance with the mandate of your Executive Order 91.

Sincerely,

Anna B. Mayer

Anna B. Mayer
Chairperson

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The Committee was fortunate to receive the assistance of more than 100 individuals who helped identify issues and contributed to the preparation of the recommendations for action. Many of these people are cited in the accompanying lists for their participation in the statewide survey, the Community Advisory Group and the Sub-Committees. Assistance was provided too, by the nurses from 22 schools who responded to a survey on child health issues.

We would like to express our appreciation to those Sub-Committee members who provided very extensive background information for this report. They include: **Stephen Eisdorfer,** Department of the Public Advocate; **Joseph Feinberg,** Department of Community Affairs; **Audrey Harris,** Division of Public Welfare, Department of Human Services (DHS); **Jane Chazkel-Hochman,** Division of Special Education, Department of Education; and **Patricia Holliday,** Office of Education, DHS.

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The responsibility for providing resources for the Governor's Committee has rested with the Department of Human Services (DHS), and we are appreciative for the cooperation that has been consistently extended by the department. DHS staff **Cathy Farley, Robert Herrera, Stan Ziolkowski, Kathy Bryce, Robert Zotta** and **Audrea Dunham** deserve a special thanks for their help. We are also very grateful for the patient assistance given by **Robert Nicholas,** DHS's liaison to the Committee, who has extended himself in many different ways to facilitate the work of the Committee.

Through the assistance of Professor **Maurice Elias,** Rutgers University, student interns were assigned to work with the Committee. Interns **Robin Baerwitz Davidson, Priscilla Helck** and **Carolyn McHale** contributed to many aspects of the Committee's work, and we thank them and Professor Elias for their help.

A note of thanks is due **Jacqueline Algayer,** member of the Commission on Children's Services, who designed the logo used for the cover of this report. We also thank **Enrique Berdecia** for the assistance he provided in designing the cover.

All of the photographs in this report were contributed by various agencies and individuals, and we thank them for their generosity. Contributing agencies and individuals include: the **New Jersey Arts Council;** the **Department of Community Affairs;** the **International Youth Organization** of Newark; the **Princeton Packet** and staff **Andrea Kane, Rich Pipeling** and **Paul Savage;** the **University of Medicine and Dentistry of New Jersey** (UMDNJ); **Anatol Kurdsjuk, Lou Krefski, Paul Shelly** and **Thomas Benjamin.** We would like to note our special appreciation for the assistance **Eve Jacobs** and **Jeff Lebaw** of **UMDNJ,** and **Paul Savage** of the **Princeton Packet** gave regarding photo contributions.

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That children's issues are in the forefront in New Jersey today is the result of the efforts of many people over the years. We would like to take this opportunity to mention the work of individuals such as **Joseph De James, Linda J. Wood** and **Joan Hammond Brame** who have made valuable contributions to the fund of knowledge about children's services. We would also like to recognize the leadership of those individuals who helped set a foundation for positive action via the Commission on Children's Services: **Yolanda Aguilar de Neely; Gail Houlihan; Gerard Thiers; Timothy Carden** and former Senator **Anthony Scardino.**

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Office of the Governor's Counsel, Trenton

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National Juvenile Law Project, Trenton

Pamela Christopher
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Joseph DeJames
Juvenile Detention and Monitoring Unit, Trenton

Cecile Dickey
Concerned Parents for Head Start, Paterson

Martha Bolds
Community Action Day Care Center, Paterson

Nelson Garcia
Youth, Trenton

Stuart Grant
Youth Consultation Service, Newark

Georgia Hartnett
New Jersey Business and Industry Association, Trenton

Lorenzo Hernandez
Hispanic Information Center, Passaic

Tynette Hills
Division of General Academic Education, Trenton

Arnold Hodes
Division of Budget and Program Review, Trenton

Karl Howell
Youth, Trenton

Gerald Johnson
Employment Services, Newark

Barbara Kelley
New Jersey Junior Leagues, Upper Montclair

Betty Layden
New Jersey League of Women Voters, Stanton

Consuelo McDaniel
Head Start Child Development Program, Inc., Trenton

Virginia McKernan
Office of Management and Budget, Camden

Joyce Mohamoud
Parents Anonymous, Piscataway

Robert Nicholas
Office of Human Services Planning, Trenton

Stephen Poset
Accident Prevention and Poison Control, Camden

James Poughan
Office of the Governor's Counsel, Trenton

Maria Rivera
Division of Emergency Services, Camden

Gail Saxer
Aide to the Legislature, Pine Beach

Ciro Scalera
Association for Children of New Jersey, Newark

Sybil Smith
New Jersey Association of Black Educators, Montclair

Wilma Solomon
Youth Services Bureau, Middlesex

Peg Stewart
New Jersey Church Women United, Moorestown

Sandra Stewart
New Jersey Junior Leagues, Fair Haven

Marilyn Treiber
Mi Escuelita Day Care Center, Perth Amboy

Wayne Wilson
New Jersey State Commission on Agent Orange, Trenton

COMMUNITY SURVEY

RESPONDENTS TO A STATEWIDE SURVEY WHO IDENTIFIED CONCERNS AND UP-DATED INFORMATION REGARDING CHILDREN'S SERVICES ISSUES

Felicia Adubato
New Jersey Speech-Language Association, Orange

Earlene Baumunk
Division of Mental Retardation, Trenton

JoAnn D. Bocchese
Special Child Health Services, Glassboro

Geraldine L. Boone
Child Placement Review Board, Princeton

John F. Boyne
Spaulding for Children, Westfield

Porter C. Brashier
Volunteer Consultant, Lawrenceville

Mark J. Byrne
New Jersey Division of Alcoholism, Trenton

Harry T. Cassidy
Youth Service Advisory Council, Mount Holly

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New Lisbon Developmental Center, New Lisbon

Pamela Christopher
County Department of Children's Services, Cherry Hill

Nancy Clark-Shakir
Coalition of 100 Black Women, Newark

Donna Clayton
Legislative Services, Camden

Diana Cohen
Atlantic Mental Health Center, McKee City

Rose Cooper
Community Council for the Prevention of Child Abuse, Jersey City

Melvin Crawford
Greater Trenton Community Mental Health Center, Trenton

Thomas R. D'Intino
Vineland Developmental Center, Vineland

Judy Donohoe
Anchor House, Trenton

Karen A. Egan
Child Placement Review, Jersey City

Dorothy Engle
The Engle School, Sparta

David Fearce
Atlantic City Boys' and Girls' Club, Incorporated, Atlantic City

Ann Finnegan
Ocean County Advisory Commission on the Status of Women, Toms River

Dennis M. Flynn
New Jersey Department of Health, Trenton

Sister Agnes Fox
Kenmare Alternate High School for Women, Jersey City

Grace Ibanez Friedman
Educational Consultant, Morganville

Marie E. Gdula
State Department of Education—Monmouth County Office, Freehold

Toni L. Goldfarb
Concerned Citizen, Teaneck

Sarah Green
Newark Foster Parent Association, Newark

Ida Gurtman
Volunteer, Passaic

Milton G. Hughes
Monmouth County Superintendent of Schools, Freehold

Mary M. Inzana
Mercer County Adolescent Coalition, Trenton

Judith Kaplan
La Leche League of Passaic County, Paterson

Vahram Kashmanian
New Jersey Commission for the Blind and Visually Impaired, Newark

Hugh Kilmer
Statewide Protective Services, Hoboken

Edward P. Kluck
Project Community Pride, Madison

Roberta Knowlton
New Jersey Network for Family Life Education, New Brunswick

Robert Mackey
Central Regional High School, Bayville

Adriano J. Marinielli
Division of Vocational Rehabilitation, Trenton

Jacqueline McBride-Jones
Community Advocate, Atlantic City

Susan Metz
4-C of Monmouth County, Freehold

Joseph Mullen
Passaic County Probation, Paterson

Carol Pecker
Elizabeth General Medical Center, Elizabeth

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Cumberland County Mental Health Board, Bridgeton

Edna Ranck
Children's Services of Morris County, Morristown

Estelle Robinson
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Karen Rosanoff
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Meyer S. Schreiber
Kean College, Union

Lynne Sproule
Marlton Youth Resource Center, Marlton

Joyce Swain Drake
Essex County Jail Annex, Caldwell

Joan Timm
Phillipsburg Day Care Center, Phillipsburg

Mary B. Towle
Sussex County Welfare, Newton

James Varanyak
Division of Aeronautics, Trenton

Judith Vichers
Division of Youth and Family Services, New Brunswick

Ann M. Wilson
New Jersey Network on Adolescent Pregnancy, New Brunswick

Naomi Yantz
New Jersey Education Association-retired, Somerville

Stephanie Zonenberg
Wife and Mother, Paterson

PREFACE

- The Committee's Mandate
- Process to Develop the Action Plan
- Seven Sub-Committees
- Interim Recommendations
- Results of the Process: Improved Communication and Cooperation

New Jersey Department of Human Services

THE WORK OF THE GOVERNOR'S COMMITTEE ON CHILDREN'S SERVICES PLANNING

THE COMMITTEE'S MANDATE

The Governor's Committee on Children's Services Planning was established in March, 1983 by Executive Order 35 to address the "deficits and a lack of coordination in the planning, provision and evaluation of services for children in New Jersey" identified by the Commission on Children's Services in its 1982 report. **Linking Policy with Need.** The Governor's Committee has functioned as a problem-solving mechanism, involving a diverse group of citizens and state department staff in a unique cooperative effort to meet these mandates:

- Review the findings and recommendations of the Commission on Children's Services and make recommendations to the Governor on priority items which could be addressed by gubernatorial action;
- Develop specific plans for the implementation of the recommendations made to the Governor;
- Recommend to the Governor, in coordination with the Supreme Court Family Court Committee, State Youth Services Commission and the Human Services Advisory Council, specific action required by state government to maximize effective implementation of Family Court legislation with particular regard to the delivery of those comprehensive services to youth and their families to be provided within the Family Court process; and
- Provide other information on children's services as the Governor may request.

Composed of 27 members appointed by Governor Kean, the Committee includes representatives from a broad range of service providers, community organizations and child advocacy groups as well as the Commissioners of seven state departments and the Director of the Administrative Office of the Courts. To assure broad input for its work, and the advice of those individuals who will actually implement the Committee's recommendations, the Governor's Committee involved many other citizens and state department staff in its deliberations. These individuals contributed to the work of the Committee through service on a special advisory group, responding to surveys conducted by the Committee and participation in the Sub-Committees.

PROCESS TO DEVELOP THE ACTION PLAN

The Governor's Committee used the report of the Commission on Children's Services as a starting point for its work. It also closely reviewed the provisions of the new Juvenile Code, the enabling legislation for the new Family Part of the Superior Court, and the **Report of the State Family Court Committee to the June 24, 1983 Judicial Conference.** From amongst the many issues identified, the Governor's Committee selected specific issues for priority action. Those issues fall within two categories:

- Broad systems problems which affect the planning and coordination of services
- Service gaps and service delivery problems in specific service areas

To establish an information base for the selection of priorities and the development of recommendations, the Governor's Committee conducted these information-gathering activities:

- A survey of all state departments to up-date the information reported in *Linking Policy with Need* and ascertain departmental priorities for action
- A meeting with a special Community Advisory Group to receive input on priority issues and needs
- A survey of community groups, service providers and public officials to obtain their recommendations for action
- A series of interviews with community members, service providers and state department staff to obtain information on specific issues and proposals for action
- A survey of school nurses to identify the types of health care services available in selected school districts, and to identify gaps in services

SEVEN SUB-COMMITTEES

The actual work of the Governor's Committee has been carried out by seven Sub-Committees, each of which focused on one of the following planning areas:

- Economic Security for Children and Families
- Health Care
- Education
- Social Services for Children and Families
- Early Childhood Development and Child Care
- Services for Emotionally Disturbed Children
- Juvenile Justice—Family Court

These Sub-Committees, each chaired by a member of the Governor's Committee, included members of the Committee as well as other community members and staff of various state departments who worked together to develop the action plan set forth here.

The recommendations detailed in this report are the result of hundreds of hours of deliberations on the part of the Sub-Committees and the full Governor's Committee. Every recommendation incorporates the suggestions of the people on the front line—those who administer and provide services for children and families, and who will ultimately be responsible for implementing the recommendations.

Finalized through formal review and vote by the full Governor's Committee, these recommendations represent the Committee's decisions regarding specific actions necessary to improve the quality of services for New Jersey's children. To illustrate the factors weighed by the Governor's Committee in arriving at its decisions, a statement summarizing those factors is provided for each recommendation in this report.

INTERIM RECOMMENDATIONS

During the course of its work, the Governor's Committee reviewed a number of issues which required immediate action in conjunction with pending legislation or budget decisions. The Committee's recommendations on these matters were given to the Governor on an interim basis so that the Governor could immediately consider them. Those recommendations, which have also been detailed in this report, include:

1. Recommendation for an increase in the benefit levels for the Aid to Families with Dependent Children program—sent to the Governor December 6, 1983
2. Recommendation for the establishment of a statewide program to screen all preschool children for lead poisoning—sent to the Governor January 4, 1984
3. Recommendation for an increase in the funding for the education of children in state facilities—sent to the Governor February 6, 1984

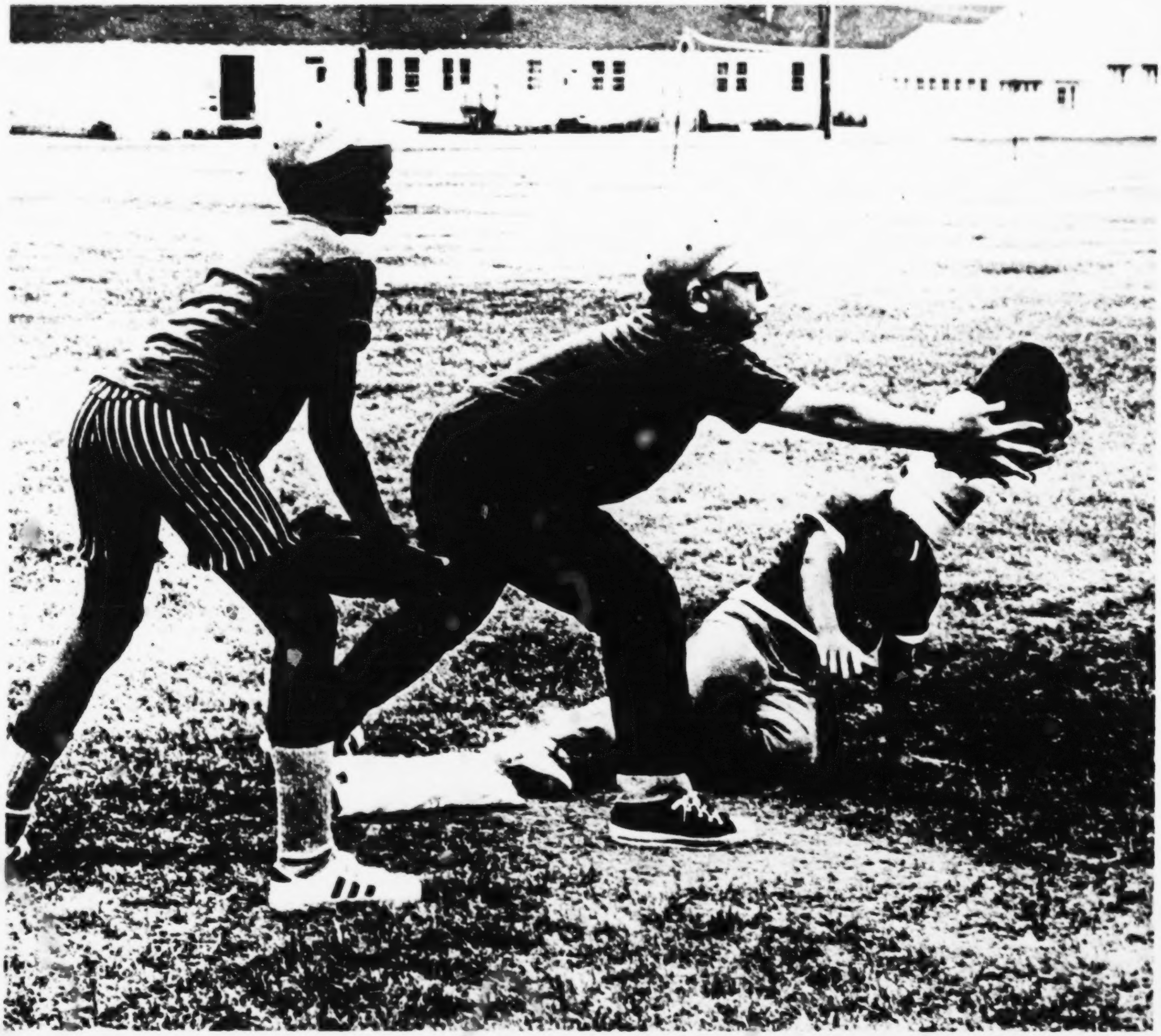
RESULTS OF THE PROCESS: IMPROVED COMMUNICATION AND COOPERATION

While the primary purpose of the Governor's Committee was to develop specific recommendations for the Governor, bringing diverse groups of people together to participate in the process has had other results which enhance the quality of services for children in New Jersey. Those results, which stem from the working relationships that developed during the process, include:

- Increased citizen knowledge of state-funded programs for children, and the needs of children in New Jersey.
- Improved communication between citizens and state department staff which has been applied to matters beyond the work of the Governor's Committee.
- Improved communication and cooperation among staffs of different state departments so that they have a better understanding of each other's programs and a basis for coordination on specific projects.

Most significantly, the many different people involved in the process left aside individual organizational concerns to focus on the needs of New Jersey's children from a broad **and** neutral perspective. Thus, the Governor's Committee has been able to develop its recommendations from a framework based upon the best interests of the children of our state.

EXECUTIVE SUMMARY



New Jersey Department of Community Affairs, R. Bender, Photographer

SUMMARY OF PRIORITY ISSUES AND RECOMMENDED ACTIONS

INTRODUCTION

New Jersey's Action Plan for Children represents the work of more than 100 public officials, service providers and citizens who participated in the deliberations of the Governor's Committee on Children's Services Planning. The report sets forth the Committee's view of priorities for action on behalf of New Jersey children, and it focuses on those problems believed to pose the greatest risk of harm to the children of this state. The recommendations represent the findings of a broad range of individuals about what needs to be done to meet the needs of children in an efficient and humane manner.

This report documents many serious problems affecting the well-being of New Jersey's children, and, as well, it identifies major shortcomings in how services are provided for children and families. Hundreds of thousands of New Jersey's children are at risk today because of problems associated with severe poverty, housing shortages, unmet health care needs, lead poisoning, adolescent pregnancy, deficient educational services, untreated mental illness, drug and alcohol abuse, and troubled family situations which increase the risk of child abuse and neglect. For example, as detailed in Chapter II, the Governor's Committee found that:

- Nearly 400,000 New Jersey children are growing up in pronounced poverty at risk of serious nutritional deficiencies and health care problems.
- There are severe housing shortages in New Jersey, and nearly 14 percent of the state's population live in substandard housing.
- New Jersey's infant mortality rate is higher than the national average.
- An estimated 220,000 preschool children are at high risk of lead poisoning.
- An estimated 30,000 teenagers become pregnant each year; in 1982 alone, over 11,000 babies were born to teenage mothers.
- An estimated 100,000 impoverished children may not be receiving adequate health care services.
- An estimated 41,810 New Jersey children suffer from developmental disabilities.
- The current formula for funding public school education has led to grave disparities in the quality of services among districts, with marked deficiencies in the urban school districts.
- Between 1983 and 1984, rates of reported child abuse rose by 50 percent from 26,398 to 45,000.
- Drug and alcohol abuse is a pervasive problem among the state's young people.
- An estimated 20 to 40 percent of the state's children risk harm from parental drug or alcohol abuse.
- Thousands of children manifest serious emotional problems, and suicide is now the second leading cause of death among New Jersey's adolescents.
- About 90,000 delinquency complaints are filed against young people in New Jersey, and another 11,000 children are referred to the courts because of parent-child conflicts.

Often, the "system" of services fails children by overlooking their critical needs or simply not responding to them in a timely manner. Further, the needs of children are not always represented in the planning process, and resources are not consistently targeted to those children who are most in need of services.

For many children, the picture is bleak because on-going neglect of their basic needs has impaired their potential for healthy growth and development. Most vulnerable are Black and Hispanic children whose families continue to bear the brunt of adverse socio-economic forces.

This report comes at a time, however, when there is strong potential for vigorous action to alleviate many of the most critical problems affecting children. Currently, there is an unprecedented level of activity on behalf of New Jersey's children with all three branches of government and community groups mounting significant initiatives to benefit children; action is even underway to address some of the problems reported here. Accordingly, this plan of action is offered to lend direction for cooperative government and community action to eliminate those problems which continue to seriously jeopardize the well-being of New Jersey's children.

* * *

Detailed hereafter is a chapter by chapter summary of the priority issues identified by the Governor's Committee and the actions recommended by the Committee.

ACTIONS TO ASSURE BASIC FOUNDATIONS FOR LIFE

TEXT—CHAPTER III

Children are dependent upon adults to meet their survival needs and to assure that the basic foundations of life are consistently provided to nurture their development. Those basic foundations for life include: nutritionally adequate food, safe and decent shelter, health care and sufficient education to develop basic skills for life and self-support.

In New Jersey, many children are growing up without these basic foundations for life because their families do not have sufficient income to meet their basic needs and government has not made adequate provisions to assure the well-being of these children. Further, many children are not receiving adequate educational services to prepare them for adulthood.

This Chapter reports the Governor's Committee's recommendations for specific actions to:

- Provide adequate income supports for impoverished families so that the basic survival needs of children can be met.
- Provide safe, decent and affordable housing for children and families.
- Provide preventive and remedial health care services for children.
- Eliminate deficiencies in the educational system.

MEETING THE NEED FOR ADEQUATE INCOME SUPPORTS THROUGH AFDC

ISSUE SUMMARY

MORE THAN 270,000 NEW JERSEY CHILDREN MUST RELY ON THE STATE'S PRIMARY INCOME SUPPORT PROGRAM, THE AID TO FAMILIES WITH DEPENDENT CHILDREN PROGRAM, TO MEET THEIR BASIC SURVIVAL NEEDS. BUT, CURRENT BENEFIT LEVELS ARE NOT SUFFICIENT TO PROVIDE EVEN BARE NECESSITIES AND THEY FOSTER FAMILY BREAK-UP.

- AFDC benefits cover less than 60 percent of the minimum cost of living in New Jersey and are far below the federal poverty guideline.
- Inflation has risen by at least 80 percent over the past decade, but AFDC benefits have been increased by only 33 percent.
- The real value of AFDC benefits has been substantially eroded.
- Many children are growing up chronically hungry and there is a growing sense of desperation among poor children and families.
- Rather than preventing homelessness, AFDC benefit levels actually help cause it because AFDC families cannot afford adequate housing.
- Reduced benefit levels for two-parent families penalize children and encourage family break-up.

RECOMMENDED ACTIONS

I. **ASSURE THAT AFDC CHILDREN WILL BE SUPPORTED AT LEAST AT THE POVERTY LEVEL**

The state should provide for increases in the AFDC grant level with a goal of assuring that children who require AFDC will be supported at least at the poverty level. While it may not be possible to achieve this goal in one step, the amount of the increase in this year's budget should be maximized. Further, the process of raising the grant to an adequate level should be continued from one year to the next.

II. **ESTABLISH PROVISION FOR AUTOMATIC INCREASES TO COMPENSATE FOR INFLATION**

The state should establish a mechanism to assure that the AFDC grant level is automatically increased to compensate for the rate of inflation in any given year.

III. **EQUALIZE BENEFIT LEVELS FOR N SEGMENT FAMILIES—FOSTER FAMILY UNITY**

To foster family unity and to remove the current financial incentive for one parent to leave the home, the benefit levels for AFDC N segment families should be increased to equalize them with the benefit levels for the C and F segment families. Benefits for the N segment should be based upon the same needs assessments and assistance standards used for the C and F segments.

HOUSING CHILDREN AND FAMILIES

ISSUE SUMMARY

THE SHORTAGE OF SAFE, DECENT AFFORDABLE HOUSING FOR FAMILIES WITH CHILDREN IS ONE OF THE MOST CRITICAL ISSUES CONFRONTING NEW JERSEY. MANY CHILDREN LIVE IN UNSAFE HOUSING CONDITIONS, AND MANY ARE DEPRIVED OF BASIC NECESSITIES BECAUSE THEIR FAMILIES MUST SPEND A DISPROPORTIONATE AMOUNT OF THEIR INCOME ON HOUSING.

- About one million New Jersey residents live in substandard housing. Many of these "inhabitants" are children who are especially vulnerable to health problems and injuries resulting from unsafe and unsanitary housing conditions.
- There is an acute shortage of safe, affordable housing and the impact is most acute for poor and urban residents.
- Currently, 76 percent of the 394,000 lower-income households in New Jersey who are renters are paying more than they can afford for shelter. Similarly, 69 percent of the lower-income families who own homes are paying more than they can afford for housing.
- Recent studies show that a substantial proportion of New Jersey's poor families must neglect the medical and nutritional needs of their children in order to pay for housing.
- Lack of housing has been identified as a major cause of family breakup resulting in the need for foster home placement for children.
- There has been a downward trend in housing growth. At the same time, there has been a sharp decline in federal support for housing.
- Local regulatory practices impede housing development.
- The state lacks a comprehensive, consistent policy to provide a framework for housing development activities. Thus, efforts to address New Jersey's housing problems have been piecemeal and uncoordinated.

RECOMMENDED ACTIONS

I. **POLICIES AND PROGRAMS TO PROVIDE SAFE, DECENT AND AFFORDABLE HOUSING**

Safe, decent and affordable housing must be available to all children and their families. In furtherance of this goal, the state should place a high priority on:

A. HOUSING DEVELOPMENT

The development of appropriate housing in all areas of the state in conformity with the decisions of the N.J. Supreme Court in Mount Laurel I and II, taking account of the need for access to employment opportunities, education, social services, transportation and the like. Home ownership should be encouraged, where possible, as pride of ownership is a strong encouragement to maintain housing stock. Further, emphasis should be placed on the development of additional public housing programs and the provision of increased technical assistance to enable municipal governments to meet their "modest income housing" needs. Additionally, the state efforts to provide financial and technical assistance to community groups, builders and developers should be expanded.

B. ALLOCATION OF MFA MORTGAGE FUNDING FOR MODEST-INCOME FAMILIES

The allocation of a specific proportion of Mortgage Finance Agency mortgage monies to modest-income families on an annual basis.

C. URBAN HOUSING—REHABILITATION AND HOMESTEADING

The development of a suitable stock of urban housing. This would include expansion of urban homesteading and rehabilitation of older housing to bring the quality of urban housing to an acceptable level.

D. DEVELOPING SUITABLE RENTAL HOUSING

The enactment of laws protecting and encouraging the development of suitable rental housing for families with income below 80 percent of the average income for their counties. The rates of conversion of rental housing to condominiums should be closely monitored to assure that such conversions do not result in seriously reducing the stock of rental housing for modest-income families.

E. RENTAL ASSISTANCE PROGRAM

The development of a rental assistance program for families whose income is below 80 percent of the county median. Such a measure, which we understand has been under consideration, would complement the Federal Section 8 Rental Assistance Program which, while extensively utilized in New Jersey, has not come close to meeting the state's need.

F. UTILIZATION OF MODULAR HOUSING

Encouraging the production and utilization of modular housing (industrially produced) since it is (exclusive of land costs) 20 percent cheaper than conventionally built housing.

II. OVERSIGHT AND COORDINATION OF HOUSING-RELATED PROGRAMS

A single entity should be given responsibility for coordination of all housing-related programs in state government. This entity should have access to the traditional housing office within the Department of Community Affairs (DCA) and the ability to work closely with other state departments such as Banking, Insurance, Environmental Protection, Law and Public Safety, and Commerce and Economic Development as well as Federal, County and local government agencies to assure that policies affecting housing are coordinated and that new programs are developed. This body should also develop new legislative initiatives needed to expand the state's housing stock.

III. ESTABLISH SPECIAL GOVERNOR'S TASK FORCE

A special Governor's Task Force should be established to act, in conjunction with the Assembly Committee on Housing and Urban Policy, in an advisory capacity to the entity charged with overall responsibility for coordination of statewide housing efforts. This Task Force should include key business leaders, representatives of the housing industry, housing advocates, academic experts on housing and public officials. It should be mandated to:

- Review current housing policies and propose statutory and administrative code revisions to facilitate the development of additional housing units.
- Consider the establishment of a permanent ombudsman office to facilitate the coordination and obtaining of necessary permits and licenses for the construction and rehabilitation of appropriate housing.
- Identify innovative methods to more efficiently use existing resources for housing.
- Propose methods of cooperatively involving communities in implementing the mandate of *Mount Laurel II* and other proposals developed to address housing needs.
- Conduct discussions with major public and private financial institutions to identify methods of expanding the pool of private financing for modest-income housing. Financing for both newly constructed units and rehabilitation should be explored. Further, the feasibility of establishing a state secondary mortgage market should be examined.

IV. PROHIBIT DISCRIMINATION

Discrimination against children and their families in access to housing should be statutorily prohibited except with regard to special housing for the elderly. Existing statutes should be amended to prohibit discrimination in the rental or sale of all housing, public and private, on the basis of parental status, marital status, legitimate source of income, age or number of children. In addition, provision should be made to increase the penalties for violation of such laws and to encourage the Division of Civil Rights and local and state prosecutorial agencies to enforce the laws.

V. MEET HOUSING NEEDS OF VULNERABLE YOUTH

The housing needs of older children and young adults who are leaving their parental homes or being deinstitutionalized are a matter of special concern. Special housing programs should be developed for these individuals which take into account their housing, personal development and service needs.

PREVENTIVE AND REMEDIAL HEALTH CARE FOR CHILDREN

This section sets forth recommendations for preventive and remedial health care services for children. The priority issues selected for action include:

- Lead Poisoning
- Medicaid Services
- Medicaid Coverage for the Medically Needy
- Coordination of Health Care Services

LEAD POISONING: PREVENTING A SERIOUS THREAT TO CHILDREN

ISSUE SUMMARY

AN ESTIMATED 220,000 YOUNG CHILDREN IN NEW JERSEY ARE AT HIGH RISK OF LEAD POISONING. BUT, SCREENING SERVICES ARE AVAILABLE TO TEST ONLY A SMALL PORTION OF THESE CHILDREN.

- New Jersey has some of the highest rates of lead poisoning reported in the nation; some localities report a rate three times the national average.
- According to the New Jersey Department of Health, lead poisoning is probably the leading childhood disease in New Jersey today. The rate of poisoning among children at risk exceeds the rate of paralytic polio at the height of the epidemic in the 1950s.
- Untreated lead poisoning can produce: learning disabilities, retardation, behavioral dysfunctions, liver and kidney damage, and death.
- Lead poisoning is most likely to occur in preschool children and can occur without the child displaying symptoms.
- The New Jersey Department of Health estimated that the costs of medical care and special education for a child suffering from the neurologic effects of lead poisoning to be $350,000 in 1978.
- Screening is the only way to document the extent of the hidden epidemic of lead poisoning among preschoolers in New Jersey.
- Screening can cause the rates of lead poisoning to drop. Chicago and New York report a decline after instituting extensive screening.
- Abatement is difficult to enforce and screening may be the more effective route to prevent lead poisoning.
- More study needs to be done to identify those children at greatest risk, the most cost effective method of prevention and the development of a statewide strategy to address the problem.

RECOMMENDED ACTION

MANDATE SCREENING FOR HIGH-RISK CHILDREN

The State should establish a statewide mandatory and comprehensive screening program to screen all children who are at high risk of lead poisoning, to treat those children identified as lead poisoned, and to develop and disseminate educational materials for those who work with children. Further:

A. STUDY TO IDENTIFY RISK TO CHILDREN

The Department of Health should perform a study to assess the full extent of lead poisoning among New Jersey's children, and to identify those population groups which are at high-risk of lead poisoning. This study should use a random sample and appropriate methodology to assess the level of risk among children from different population groups, and, as well, the study should specifically assess the extent to which children living in areas considered low-risk by currently used criteria are in fact affected by lead poisoning. This study should be initiated and completed within the next 15 months.

B. FUNDING

The sum of $1 million should be appropriated to the Department of Health in order to perform the study, and re-open the lead screening programs which were closed due to lack of funding.

C. ESTABLISH ADVISORY COUNCIL

An Advisory Council should be established to guide the development and implementation of an adequate screening program to ensure the screening of all children who are at high-risk of lead poisoning. The Council should also review the results of the Department of Health's study once it has been completed to determine whether the results indicate that all children are at risk and should therefore be screened. Membership of the Council should include representatives of the New Jersey Senate and Assembly, public health physicians, coordinators of municipal childhood lead poisoning prevention programs, physicians who specialize in lead poisoning control, the parents of children at risk of lead poisoning, and the Commissioner of Health or his designee.

MEDICAID: IMPROVING THE QUALITY OF HEALTH CARE SERVICES

ISSUE SUMMARY

MORE THAN 300,000 IMPOVERISHED CHILDREN IN NEW JERSEY DEPEND UPON MEDICAID TO RECEIVE HEALTH CARE SERVICES. HOWEVER, MANY ELIGIBLE CHILDREN DO NOT RECEIVE PREVENTIVE HEALTH CARE SCREENINGS AUTHORIZED UNDER THE PROGRAM, AND MANY ARE DENIED NECESSARY MEDICAL SERVICES BECAUSE LOW RATES OF REIMBURSEMENT DISCOURAGE PHYSICIANS FROM TREATING MEDICAID PATIENTS.

- Low-income children are at higher risk of illness and disabilities than other children.
- Relatively little has been done to assess the effectiveness of Medicaid services in meeting the health care needs of poor children in New Jersey.
- The Early Periodic Screening, Diagnosis and Treatment (EPSDT) program is underutilized. In 1983, only 10.9 percent of the eligible New Jersey children received EPSDT screenings.
- Current outreach efforts to inform parents of the EPSDT program are not adequate. One survey of Head Start parents showed that nearly 60 percent of the parents had never heard of the EPSDT program.
- Many physicians will not accept Medicaid patients because the reimbursement rates do not cover the actual costs of ambulatory care. Thus, it has become increasingly difficult for Medicaid children to obtain preventive health care services.
- Poor families cannot find physicians to serve them, and they are forced to use hospital emergency rooms for primary, non-emergency care.

RECOMMENDED ACTIONS

I. VIGOROUS OUTREACH AND PROVISION OF EPSDT—REASSIGN TO DEPARTMENT OF HEALTH

The outreach and screening functions of the Early Periodic Screening Diagnosis and Treatment (EPSDT) program should be transferred from the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) to the Department of Health. The Department of Health should be directed to adminster these functions as part of its overall responsibility for planning and coordinating state and local health services for children. Further:

A. These functions should be carried out in an advocacy manner designed to prevent unnecessary maladies in children and to prevent the need for expensive emergency treatment.

B. The Department of Health should implement a plan to accomplish 100 percent enrollment of all children eligible for Medicaid in the EPSDT program. The Department's implementation plan should utilize all available state and community resources, augmented where necessary and orchestrated on the local level by the Department.

II. EVALUATE SERVICE EFFECTIVENESS

Data should be collected and analyzed in order to evaluate the efficacy of the Medicaid program and its services for children.

III. ESTABLISH COMPREHENSIVE PREVENTIVE HEALTH CARE PROGRAM

DMAHS should work cooperatively with physicians to establish an appropriately comprehensive and continuing program of preventive health care for the children of New Jersey.

IV. EVALUATE ADEQUACY OF MEDICAID REIMBURSEMENT RATES

The state should evaluate the adequacy of current Medicaid rates of reimbursement to physicians for health services for children, and readjust the rates to the extent necessary to assure that physicians receive a reasonable fee for the services.

MEDICAID COVERAGE FOR THE MEDICALLY NEEDY

ISSUE SUMMARY

NEW JERSEY'S CURRENT MEDICAID ELIGIBILITY GUIDELINES ARE BASED UPON VERY STRINGENT INCOME GUIDELINES WHICH EXCLUDE THOUSANDS OF FAMILIES WHOSE INCOMES ARE BELOW THE POVERTY LEVEL. AN ESTIMATED 100,000 NEW JERSEY CHILDREN FROM IMPOVERISHED FAMILIES DO NOT MEET THE CURRENT CRITERIA FOR MEDICAID ELIGIBILITY, AND THESE CHILDREN MAY NOT BE RECEIVING NECESSARY MEDICAL AND DENTAL SERVICES BECAUSE THEIR PARENTS CANNOT AFFORD TO PAY FOR THE SERVICES. FURTHER, ABOUT 3,000 IMPOVERISHED PREGNANT WOMEN CANNOT QUALIFY FOR MEDICAID AND DO NOT RECEIVE PROPER PRENATAL CARE BECAUSE THEY CANNOT AFFORD TO PAY FOR THE SERVICES.

- Eligibility limits for Medicaid coverage are 35 percent below the annual income levels for an adequate standard of living in New Jersey.
- New Jersey has not exercised the Medically Needy option of Medicaid while over 30 other states have.
- Changes in the AFDC standards resulted in making at least 18,500 children ineligible for Medicaid and as many as 40,500 may have been removed from Medicaid. For the families removed from Medicaid, a Rutgers University study found:
  - —56 percent did not have medical coverage for their children.
  - —78 percent reported a medical or dental problem for which they could not obtain services because of the costs.
  - —49 percent could not afford care for a child's severe medical problem.
  - —Almost one third could not afford to provide eyeglasses or dental care for their children.
- Hospitals have been seeing more minor problems that have escalated into crisis situations because treatment had not been sought soon enough.
- Preventive health care services have been shown to be cost effective and result in substantial long term savings. Provision of Medicaid coverage for low-income children would eliminate a major barrier to receiving necessary health care services.
- Extending coverage to parents would result in the added benefit of protecting children from the adverse effects of parental medical problems.

RECOMMENDED ACTION

The State should establish a Medically Needy Program providing Medicaid coverage for all children whose families' incomes are below the level required for a minimally adequate standard of living in New Jersey. The Medically Needy Program should also provide Medicaid coverage for pregnant women within the same income level.

COORDINATION OF HEALTH CARE SERVICES

ISSUE SUMMARY

MANY DIFFERENT STATE AND LOCAL AGENCIES ARE INVOLVED IN PROVIDING HEALTH CARE SERVICES FOR NEW JERSEY'S CHILDREN. HOWEVER, NO SINGLE ENTITY OPERATES TO COORDINATE THE PLANNING AND PROVISION OF THESE SERVICES SO THAT MAXIMUM USE CAN BE MADE OF EXISTING RESOURCES FOR HEALTH CARE.

RECOMMENDED ACTIONS

I. INTER-DEPARTMENTAL COORDINATION

Through the proposed Governor's Commission for Children and Youth (see Chapter VI), a standing Inter-Departmental Committee on the Health Status of New Jersey's children should be established and chaired by the Commissioner of Health. This Committee should have at least two members who are not state government staff, and it should:

- Assess and monitor the health status of children served by the various state agencies.
- Identify problems and gaps in the delivery of health care services for children.
- Assess and monitor the overall health care needs of children in the context of the family and society.
- Quantify the outcomes of services wherever possible.
- Make recommendations for policies, planning and procedures to alleviate gaps in services and improve service delivery.

Further, this Committee should be required to prepare an annual report to the Governor on the Health Status of children in New Jersey.

II. INTRA-DEPARTMENTAL COORDINATION

The Departments of Health, Human Services, Education and Corrections should organize their respective units which address children's health issues into a single administrative unit wherever feasible. Where this is not possible, an Intra-Departmental Committee should be established to assure internal coordination of services, avoid duplication of effort, identify systems issues and develop recommendations for broad action by the Inter-Departmental Committee.

MEETING EDUCATIONAL NEEDS

This section focuses on those issues which affect the quality of educational services for New Jersey's children. Five issues were selected for action:

- Financing public school education
- School suspension practices and policies
- Under-enrollment of Hispanic school-age children
- Funding for education of children in state facilities
- Educational services for children in county residential facilities

FINANCING PUBLIC SCHOOL EDUCATION

ISSUE SUMMARY

THE CURRENT FORMULA FOR FUNDING PUBLIC SCHOOL EDUCATION HAS LED TO GRAVE DISPARITIES AMONG NEW JERSEY'S SCHOOL DISTRICTS IN THE QUALITY OF EDUCATIONAL SERVICES PROVIDED FOR THE STATE'S CHILDREN. THESE DISPARITIES IMPACT MOST SEVERELY UPON POOR AND MINORITY CHILDREN IN THE URBAN SCHOOL DISTRICTS.

- Children in **all** school districts **are not assured** an equal opportunity for a thorough and efficient education as required by the State's Constitution.
- Property wealth remains a major factor in determining how much districts spend on education.
- Highest spending districts have, on the average, 30 percent more total staff per 1,000 pupils than the lowest spending districts.
- About 70 percent of New Jersey's minority students attend school in the lowest wealth districts.

RECOMMENDED ACTION

A Blue-Ribbon Commission of qualified persons, including experts in education, finance, process and citizen advocacy should be established to prepare recommendations to the Governor and the Legislature for revisions in the State's current system for financing public education.

The mandate of the Commission should be to develop revisions which would: eliminate the grave disparities among educational districts; assure that children in all school districts have equal opportunity for a thorough and efficient education as required by the State's Constitution; and assure equality of programs and services to populations with special needs regardless of the child's residence.

SCHOOL SUSPENSION PRACTICES AND POLICIES: REDUCING THE RATE OF SUSPENSIONS

ISSUE SUMMARY

NEW JERSEY SCHOOLS HEAVILY RELY UPON SUSPENSION TO DISCIPLINE STUDENTS, AND, SINCE 1977, MORE THAN 84,000 CHILDREN HAVE BEEN SUSPENDED FROM SCHOOL AT LEAST ONCE IN EACH SCHOOL YEAR. FURTHER, THERE ARE WIDE VARIATIONS AMONG SCHOOL DISTRICTS IN SUSPENSION PRACTICES, AND THE AVAILABLE DATA SHOW THAT THERE IS A DISPROPORTIONATELY HIGH RATE OF SUSPENSION FOR MINORITY STUDENTS.

- Although the total number of secondary school students has declined by more than 14 percent, the overall rate of suspension has increased.
- There is insufficient monitoring of suspension practices and little is known about the full extent of suspension use in New Jersey. Data is not available to show how many times an individual student is suspended.
- Suspension fosters other problems: denies troubled children help, labels children as troublemakers and contributes to juvenile delinquency by putting unsupervised children with problems onto the streets.
- The incidence of suspension is more a function of school policies and practices than of students' behaviors.
- There are strong indications that suspension is applied for very minor offenses and imposed arbitrarily when other, less drastic measures could be used to discipline a student.
- There are wide, unexplained variations among school districts in suspension rates.
- Minority children are more likely to be suspended: they represent 27 percent of the total enrollment but 37 percent of the suspensions.
- The law does not require schools to use less drastic alternatives.

- Effective alternatives to suspension can significantly reduce referrals to court, truancy and physical assaults on pupils and teachers.

RECOMMENDED ACTIONS

I. DEVELOP STATE GUIDELINES

The Department of Education must develop guidelines to establish a framework for planning, implementing, and evaluating suspension and expulsion practices and programs which assure that each student is provided an educational program which effectively decreases the behavior(s) leading to the need for disciplinary action.

II. LOCAL POLICIES, PRACTICES, STAFF TRAINING AND ALTERNATIVE PROGRAMS

School districts must develop and implement disciplinary **practices and policies which assure:**

A. That pupils being disciplined are being provided continuous education in compliance with Thorough and Efficient programs.

B. That there is a continuum of educational programs to address the needs of this population.

C. That the community is informed, involved and supportive of these programs.

D. That pupils are educated in a group setting as opposed to being isolated as in home instruction.

E. **That school personnel are trained to:**

   1. Sensitize personnel as to how their own attitudes and values may result in differential treatment of students and provoke negative student reactions.
   2. Increase personnel understanding of cultural and economic influences on students and their parents.
   3. Show personnel how to identify troubled students early on.
   4. Make personnel aware of practices likely to cause discipline problems.
   5. Illustrate methods of promoting positive student behavior and motivation.

F. **That a range of alternatives to suspension** which meet Department of Education criteria are uniformly available and utilized such as:

   1. The alternative programs suggested in the *Department's Alternative Education Programs for Disruptive Students.*
   2. Vocational education programs. These children should not be excluded from such programs.
   3. The models developed by communities involved with the State Community Organization Project (SCOP) to address the needs of this population.
   4. The alternative education programs developed by the New Jersey Department of Corrections.
   5. Those programs in the resource guide created by the Interagency Youth Development Consortium and the Association for Children of New Jersey which can be adapted for use by the schools.
   6. The model programs available through the Education Information Resource Center which have proven effective in reducing suspensions and expulsions.

III. STATE MONITORING OF LOCAL PRACTICES

The Department of Education (D. of Ed.) should monitor the disciplinary practices of the local school districts to assure that the Department's guidelines are followed and no district relies unnecessarily on suspension to sanction students. To this end, the D. of Ed. should formally monitor local school districts' suspension practices on an annual basis, and review the findings as part of the certification process. School districts which evidence excessive and unwarranted use of suspension should not be certified by the D. of Ed. until a plan for corrective action has been established by the school district. Further:

A. Local school districts should be required to maintain logs of all disciplinary actions that result in a child's suspension or expulsion from school. A running log should be developed to indicate the number of times and number of days each child is excluded from school. The log should specify: reason for the action; all that has been done previously to handle the problem with the student, including alternative methods of discipline; the nature and extent of the sanction; the policy which has been violated; and the age, sex and race of the student.

B. These logs should be forwarded monthly to the county superintendent who should report this information on a quarterly basis to the Commissioner of Education.

C. The county superintendent should monitor the due process aspects of the exclusion issue.

UNDER-ENROLLMENT OF HISPANIC SCHOOL-AGE CHILDREN: ASSESSING THE PROBLEM

ISSUE SUMMARY

AVAILABLE DATA SUGGEST THAT THERE IS A STATEWIDE PROBLEM OF UNDER-ENROLLMENT OF HISPANIC SCHOOL-AGE CHILDREN. THE FULL EXTENT OF THE PROBLEM AND THE REASONS FOR THE PATTERN OF UNDER-ENROLLMENT HAVE NOT BEEN ASSESSED.

RECOMMENDED ACTION

The Department of Education should place priority on alleviating the problem of under-enrollment of

Hispanic school-age children and take these steps to address the problem:

A. **Conduct a comprehensive survey** of the school-age and preschool populations to identify the actual extent of the problem and the underlying reasons for it. Survey measures should include welfare departments, WIC programs and day care centers as well as those agencies which specifically serve Hispanic families.

B. **Develop an outreach program** to identify Hispanic children who are not enrolled in school and to make provisions for their enrollment. The cooperation of Hispanic community-based agencies should be obtained for this effort.

C. **Provide a representative** of the Department of Education to consult with the Advisory Commission on Hispanic Affairs and/or the Advisory Committee on Hispanic Affairs regarding the efforts to address this problem.

FUNDING FOR EDUCATION OF CHILDREN IN STATE FACILITIES

ISSUE SUMMARY

SUFFICIENT FUNDING IS NOT PROVIDED TO MEET THE EDUCATIONAL NEEDS OF THE 4,000 NEW JERSEY CHILDREN IN 94 FACILITIES UNDER THE JURISDICTION OF THE STATE. EDUCATIONAL SERVICES FOR THESE CHILDREN, MANY OF WHOM HAVE SERIOUS HANDICAPPING CONDITIONS, ARE DEFICIENT BECAUSE THE EXISTING CATEGORICAL AID FACTORS ARE INAPPROPRIATE TO THE STUDENT LEVEL OF NEED.

RECOMMENDED ACTION

The state should provide categorical aid sufficient to meet the educational needs of children in state facilities and to assure that they are provided with the same quality of educational services given other children.

EDUCATIONAL SERVICES FOR CHILDREN IN COUNTY RESIDENTIAL FACILITIES

ISSUE SUMMARY

STATE LAW DOES NOT CURRENTLY MANDATE THAT EDUCATIONAL PROGRAMS BE PROVIDED FOR THE MORE THAN 14,000 CHILDREN ADMITTED ANNUALLY TO COUNTY RESIDENTIAL FACILITIES SUCH AS SHELTERS AND DETENTION CENTERS. ALTHOUGH MANY OF THESE CHILDREN STAY IN THE FACILITIES FOR 30 DAYS OR MORE, THEY OFTEN ARE NOT GIVEN ADEQUATE EDUCATIONAL SERVICES OR SENT TO THEIR LOCAL SCHOOLS TO CONTINUE THEIR EDUCATION.

RECOMMENDED ACTION

MANDATE AND PROVIDE EDUCATIONAL PROGRAMS IN COUNTY FACILITIES

The state should mandate that appropriate educational programs and services be provided for all children residing in short-term county residential facilities including but not limited to detention centers, shelters for children placed by the Family Part of the Superior Court as a result of juvenile-family crises, and shelters for neglected and abandoned children. Further, the mandated programs and services should:

- Be **adapted to the unique educational** needs of the children.
- Include an **individualized written plan** for each child which meets the individual educational needs of the child.
- Afford appropriate **credit and certification** for the successful completion of particular courses or activities.
- Be provided in the **least restrictive environment** possible, using the services of educators and the facilities of public and private schools in the community of origin or the local community where appropriate and in accordance with state law.
- Be developed in accordance with regulations established by the New Jersey Department of Education with the cooperation of the Departments of Human Services and Corrections.

Pending legislation, S.1282, would provide the necessary mandate for the implementation of these educational programs and services.

ACTIONS TO IMPROVE PREVENTIVE AND SUPPORTIVE SERVICES FOR CHILDREN AND FAMILIES

TEXT—CHAPTER IV

Many families need assistance at some point in providing for the healthy development of children and supporting the well-being of the family as a whole. In response to this need, a broad range of services has been developed with public and private funding.

This chapter reports the Committee's recommendations for improvements in the organizational arrangements used to provide these services, and also reports recommendations for additional services to address specific needs. Three sections are included:

- Steps to Unify the Social Services system and make services more accessible for children and families.
- A plan for a Comprehensive Early Childhood Development Program for disadvantaged children to assure that they receive the stimulation and preventive services necessary for healthy development.
- Actions to meet the growing need for Child Care services.

STEPS TO IMPROVE THE SOCIAL SERVICES SYSTEM

ISSUE SUMMARY

NEW JERSEY'S VAST ARRAY OF PUBLIC AND PRIVATE RESOURCES FOR SOCIAL SERVICES IS NOT ORGANIZED INTO A UNIFIED SYSTEM OF FAMILY-CENTERED SERVICES.

- The current organizational scheme fosters fragmentation and duplication of services.
- Accountability for individual clients is diminished.
- Sufficient community-based preventive services have not been established.
- There is no single, non-stigmatizing service center where all families can obtain information and assistance.
- Citizens cannot easily obtain information about available services. County-wide information/referral services have not been established in most counties.
- Appropriate services are not consistently provided for Black and Hispanic families.

RECOMMENDED ACTIONS

I. CONTINUE AND EXPAND EFFORTS TO UNIFY SERVICES

The Department of Human Services (DHS) should continue and expand its efforts to unify services at the county level. Further, DHS should take these additional steps:

A. PILOT PROGRAM

Initiate a pilot program in one or more counties to test the efficiency and effectiveness of combining the services now administered by the County Welfare Agencies and DYFS into a single system for individuals, families and children which:

- Uses a "family welfare" approach placing priority on strengthening families;
- Provides developmental resources defined by the community as appropriate for all children and families, not only the "poorest," the "sick," or the "maladjusted";
- Provides early intervention for abuse and neglect; and
- Provides services to enhance early childhood development.

B. CO-LOCATION AND MULTI-DISCIPLINARY TEAMS

Place increased emphasis on developing:

- Co-location projects which bring different agencies to work together at the same physical location, so that the agencies are jointly housed, and
- Multi-disciplinary teams of professionals from different agencies to jointly evaluate the needs of individual clients and to plan services for them.

II. FUNDING FOR PREVENTIVE SERVICES

The state should provide sufficient funding for DHS to fully implement its plan for the development of additional preventive and community-based services.

III. IMPROVE SERVICES FOR BLACK AND HISPANIC CHILDREN AND FAMILIES

DHS should continue its efforts to make the department's various services more relevant to the needs of Black and Hispanic children and families through steps such as: increasing the percentage of Black and Hispanic staff members at all levels of management and in direct services, and continuing the current priority on utilization of those community-agencies which demonstrate the capacity to provide culturally sensitive services.

A PLAN FOR A COMPREHENSIVE EARLY CHILDHOOD DEVELOPMENT PROGRAM

ISSUE SUMMARY

THOUSANDS OF NEW JERSEY CHILDREN FROM DISADVANTAGED FAMILIES SUFFER FROM A BROAD RANGE OF MEDICAL, NUTRITIONAL, INTELLECTUAL AND EMOTIONAL DEPRIVATIONS. AS A RESULT, THESE CHILDREN ARE LIKELY TO EXPERIENCE PERMANENT DEVELOPMENTAL DISABILITIES WHICH REQUIRE COSTLY REMEDIAL SERVICES AND IMPAIR THEIR ABILITY TO BECOME PRODUCTIVE MEMBERS OF SOCIETY. CURRENTLY, EARLY CHILDHOOD DEVELOPMENT SERVICES ARE AVAILABLE FOR ONLY A SMALL PERCENTAGE OF THESE CHILDREN.

- At least 45,000 children in New Jersey between the ages of 3-5 years are growing up in families whose incomes are below the poverty level.
- Many of these disadvantaged children live in poverty depressed slums, and in segregated, overcrowded and often unsafe housing.
- Children growing up in poverty have been shown to be at high risk of "developmental attrition," evidenced by a decline in developmental functioning even prior to entering school.
- Comprehensive early childhood development programs have proven to be highly cost-effective for disadvantaged children. Studies have shown that children who have attended such programs require less remedial education, are more likely to graduate from high school, and have lower rates of arrests.

- Children of non-poor parents are far more likely to attend preschool programs than impoverished children.
- Federal Head Start funds have been provided to establish early childhood development programs in New Jersey, but the funds are sufficient to serve only 20 percent of the eligible children.

RECOMMENDED ACTION

ESTABLISH STATE COMPREHENSIVE EARLY CHILDHOOD DEVELOPMENT PROGRAM

To meet the Governor's mandate that "New Jersey's children should be afforded the opportunity to develop to their fullest potential," the state should establish a Comprehensive Early Childhood Development Program for children ages three to five who live in families whose incomes fall below the federal poverty guideline.

A. PROGRAM ADMINISTRATION, PLANNING AND MONITORING

The Comprehensive Early Childhood Development Program should be administered by the Department of Human Services and should be planned, implemented and monitored by an Inter-Departmental Council composed of experts from the Departments of Human Services, Health and Education in accordance with the attached guidelines.

B. FIVE-YEAR IMPLEMENTATION PLAN

The program should be fully implemented over a five-year period. In the first program year, the state should serve 5,000 children. In each successive year, the number of children served should be incrementally increased until all eligible children are afforded the opportunity to participate in the program.

CHILD CARE SERVICES: MEETING THE GROWING NEED

ISSUE SUMMARY

CHILD CARE NEEDS ARE LARGELY UNMET IN NEW JERSEY AND THE DEMAND FOR CHILD CARE SERVICES IS RAPIDLY INCREASING. FURTHER, PLANNING FOR CHILD CARE SERVICES HAS BEEN IMPEDED BY THE FACT THAT A COMPREHENSIVE NEEDS ASSESSMENT HAS NOT BEEN DONE TO IDENTIFY THE FULL EXTENT OF THE NEED.

- An estimated one million New Jersey children aged infancy to 13 years have working mothers; about half of these children are preschoolers.
- Organized, center-based child care is available for less than 20 percent of the children whose mothers work.
- Many children receive marginal care or no supervised care at all while their parents work.
- There are an estimated 250,000 "latchkey" children in New Jersey, elementary school children who care for themselves both before and after school while their parents work.
- There is no comprehensive listing of family day care homes in New Jersey. Nor is there any guarantee that these private child care providers offer a safe or healthy environment for children.

RECOMMENDED ACTIONS

I. STATE LEADERSHIP IN ASSURING AVAILABILITY OF CHILD CARE SERVICES

The state should take a leadership role in assuring that safe, affordable child care is available for the children of parents who work. Further, sufficient child care services should be available for those children at risk of abuse and neglect, and to provide respite care for children whose handicapping conditions place on-going stresses upon their families.

II. COMPREHENSIVE PLAN GUIDED BY NEEDS ASSESSMENT

The new Advisory Council on Child Care should be directed to:

A. Conduct a comprehensive needs assessment to determine the full extent of child care needs in New Jersey by age groups, geographical location and income levels. This needs assessment should specifically examine the need for extended day care services for "latchkey" children, and the need for specialized child care services for abused children as well as for handicapped children.

B. Develop a comprehensive plan for meeting child care needs. This plan should specify priorities for developing additional child care services, and should include use of innovative approaches such as expanded use of local schools for child care services, use of neighborhood centers/agencies, and use of volunteer organizations.

III. CENTRALIZED INFORMATION AND REFERRAL SYSTEM

The new Advisory Council on Child Care should be given responsibility for establishing a centralized information and referral system to maintain an inventory of available child care services; to provide information on available services to parents; and to provide technical assistance for child care providers or others interested in developing child care programs.

IV. PROMOTE DEVELOPMENT OF EMPLOYER-SPONSORED CHILD CARE SERVICES

The state should assume a strong leadership role in promoting the development of employer-sponsored child care services, and should provide incentives to employers to encourage them to support services. Further, the state, as one of New Jersey's largest employers, should provide leadership on this issue by convening the proposed Inter-Departmental Committee on Child Care which has been recommended to study the need of state government employees for child care services and to make recommendations to meet the need.

ACTIONS TO ADDRESS PHYSICAL, EMOTIONAL AND BEHAVIORAL DISORDERS

TEXT—CHAPTER V

Most New Jersey children reach adulthood free of seriously disabling physical or emotional problems. But, substantial numbers of the state's children are either born or afflicted during childhood with major physical or emotional problems which, if left untreated, can result in life-long disabilities and dependency.

Further, many of the state's young people are today at risk of the harm resultant from either their own or parental abuse of alcohol and/or narcotic substances. Additionally, thousands of young people are evidencing troubled behavior which results in their being brought before the courts either because their families cannot cope with them or because they have committed a criminal offense.

This chapter reports the Committee's recommendations for the planning and provision of services to prevent as well as treat physical, emotional and behavioral disorders among New Jersey's young people. The recommendations include actions to provide:

- Early intervention services for handicapped children
- Mental health services for emotionally disturbed children
- A continuum of prevention and treatment services to stem the problem of substance abuse
- A full range of programs for troubled children, youth and families whose problems might result in their being brought before the Family Court

Donna Pincavage

EARLY INTERVENTION SERVICES FOR HANDICAPPED CHILDREN

ISSUE SUMMARY

ABOUT 4,000 NEW JERSEY CHILDREN UNDER THREE YEARS OF AGE REQUIRE EARLY INTERVENTION SERVICES TO ALLEVIATE HANDICAPPING CONDITIONS WHICH MAY IMPEDE THEIR ABILITY TO LEARN AND FUNCTION IN A SCHOOL SETTING. CURRENT SERVICE PROVISIONS ARE NOT ADEQUATE TO REACH MANY OF THESE HANDICAPPED CHILDREN.

- In 1985, services will be available for only half of the eligible children. Plans have been developed to implement services for all the children who need them, but these plans are dependent upon the provision of additional funding.
- Insufficient outreach is conducted to inform parents of the services and to identify children in need.
- Inadequate transportation provisions are a barrier to services for some children.
- Current guidelines do not include those children who are at risk of developmental delay because of environmental factors or health factors alone.

RECOMMENDED ACTIONS

I. FUNDING

The state should provide sufficient funding for continued support of the Department of Education's proposed phase-in plan which would provide services for all eligible children by FY 1985-86.

II. TRANSPORTATION

Transportation needs should be carefully assessed and appropriate measures should be taken to assure that programs are accessible for all eligible children, especially those in rural and inner city areas where transportation problems are most common.

III. OUTREACH

Improved methods of outreach should be developed to ensure early referral of all eligible children. A concrete outreach plan should be developed and implemented by both state and local agencies.

IV. DATA COLLECTION

A data collection mechanism which organizes and analyzes the data necessary for comprehensive statewide planning and evaluation should be established. The mechanism should utilize all existing data which is currently being collected by various agencies.

V. CORE TEAM

The current composition of the core team should be maintained, and the specific inclusion of other specialists, such as the child psychiatrist, developmental pediatrician and learning disability teacher/consultant should be encouraged where appropriate to meet the child's needs.

VI. ROLE OF PHYSICIANS

Physicians should have a role in both the diagnostic and prescriptive phases of early intervention programs. This involvement should include case follow-up after implementation of the service plan to assess the efficacy of the services.

VII. NEEDED PROFESSIONALS

The Department of Higher Education should, in concert with the Departments of Education, Health and Human Services, assess the need for trained professionals in early intervention programs, and take appropriate steps to increase the available pool of needed professionals.

VIII. STUDY AT-RISK POPULATION

The Departments of Education, Health and Human Services should conduct an in-depth study of the "at-risk" infant population and identify those factors which might contribute to placing a child at risk of developmental delay. Further, the three departments should examine the feasibility of expanding the eligibility criteria for early intervention programs to include infants and children at risk of developmental delays from health and environmental factors alone.

IX. INTER-DEPARTMENTAL COOPERATION

The close cooperation among the Departments of Education, Health and Human Services in planning and implementing early intervention programs should be continued.

MENTAL HEALTH SERVICES FOR CHILDREN

This section reports the Governor's Committee's recommendations for mental health services for children. Two service issues are addressed:

- **Community-based services**
- **Specialized services for emotionally disturbed juvenile offenders**

COMMUNITY-BASED MENTAL HEALTH SERVICES

ISSUE SUMMARY

SUBSTANTIAL PROGRESS HAS BEEN MADE IN IMPROVING THE OVERALL QUALITY OF MENTAL HEALTH SERVICES, BUT MANY EMOTIONALLY DISTURBED CHILDREN DO NOT HAVE ACCESS TO APPROPRIATE COMMUNITY-BASED SERVICES AND PARTIAL CARE PROGRAMS.

- More than 1,000 New Jersey children receive care in psychiatric hospitals or residential centers each year, and as many as 15,000 school-age children have been found to have serious emotional problems.
- Suicide is now the second leading cause of death among adolescents in New Jersey.
- There are indications that a fair proportion of the federal and state funds provided to the counties for community mental health services are not being allocated to services for children.
- Children's needs do not receive proper attention in the county planning process for use of community mental health funds.
- Sufficient support services are not provided at the community level for emotionally disturbed children and their families.
- Families who do not receive adequate community-based support services to cope with a very troubled child are at high risk of stresses that can result in serious family dysfunctions and even the outright rejection of the child.
- Partial care programs can avert the need for out-of-home placement of a seriously disturbed child, and they are generally far less expensive than institutional placement.
- A sufficient number of partial care programs has not been developed in New Jersey to meet the need.

RECOMMENDED ACTIONS

I. COUNTY PLANNING AND FUNDING OF SERVICES

The counties should be required to place additional emphasis on identifying children's needs for mental health services, and planning community services for them. Further, a fair proportion of available federal and state funding for community mental health services should be allocated to services for children. To this end, these steps should be taken:

A. Legislation should be enacted to require each county mental health board to establish a children's advocacy committee to assess and represent children's needs in the county planning process.

B. The Department of Human Services through its Division of Mental Health and Hospitals (DMHH) should take administrative action to assure that at least 27 percent of the new funds provided by the increase in the per capita funds for mental health services be allocated to services for children in the community.

II. ESTABLISH ADDITIONAL PARTIAL CARE PROGRAMS FOR TROUBLED CHILDREN

The state should, through DMHH, provide fiscal support and technical assistance for the development of additional community-based partial care programs for emotionally disturbed children at risk of institutional placement, and for children returning home from psychiatric facilities, residential schools and other out-of-home placements.

SPECIALIZED SERVICES FOR EMOTIONALLY DISTURBED JUVENILE OFFENDERS

ISSUE SUMMARY

MANY OF THE CHILDREN COMMITTED TO THE DEPARTMENT OF CORRECTIONS (DOC) HAVE PSYCHOLOGICAL PROBLEMS, AND SUBSTANTIAL NUMBERS OF THESE CHILDREN HAVE SERIOUS PSYCHIATRIC DISORDERS. HOWEVER, DOC DOES NOT HAVE THE RESOURCES TO PROVIDE THE NECESSARY TREATMENT SERVICES FOR THESE CHILDREN.

- Most children committed to DOC have psychological problems.
- As many as 20 of the children sent each year to correctional facilities are so disturbed that they require specialized services.
- The state correctional facilities are neither designed nor funded to provide a therapeutic en-

vironment for children with serious psychiatric disorders.

- Many children are ultimately released to the community with serious, unabated emotional problems. Few after-care services are available for them.
- Little has been done in the way of collaborative efforts to coordinate services for these children, and to develop resources to serve them.

RECOMMENDED ACTION

ESTABLISH DEMONSTRATION PROJECT

A two-year demonstration project of specialized services should be established for 20 severely disturbed juvenile offenders who have been committed to the Department of Corrections (DOC). The sum of $800,000 should be appropriated to DOC for each of the two years to provide the services. Further:

A. ADVISORY TEAM TO DEVELOP SERVICES

An Advisory Team should be established by DOC to guide the development and provision of services. In addition to DOC staff, the Advisory Team should include representatives of: the Divisions of Mental Health and Hospitals and Youth and Family Services of the Department of Human Services; the appropriate divisions of the Department of the Public Advocate; and the Community Mental Health Agencies Association.

B. CASE REVIEW AND INDIVIDUALIZED PLANS

1. The Advisory Team should review the case of each youth referred for services and prepare an individualized plan of services for each youth who requires specialized services. The individualized service plans should be tailored to the unique needs of the youth, and should include use of innovative approaches drawn from models such as the Teaching Parent Program, Outward Bound and therapeutic work experiences where appropriate. Emphasis should be placed on using the least restrictive services suitable for the youth, and the plan should also utilize services offered by community-based agencies wherever possible.
2. In reviewing the cases of youth referred for services, the Advisory Team should carefully screen each case to determine if the youth requires on-going services. If, after screening, it is apparent that a youth's primary problem is psychiatric as opposed to delinquency, the Team should report its findings to DOC and should make a recommendation for an alternative placement for the youth to be effectuated by recall of the Family Court.

C. EVALUATE PROJECT EFFECTIVENESS

An interim evaluation should be performed at the end of the first year of the project's existence, and a second evaluation should be done at the conclusion of the second year of the project to: assess the project's effectiveness in meeting the needs of the youth, identify on-going gaps in services for this population, and develop a profile of the characteristics of the youth referred to the project.

PREVENTION AND TREATMENT TO STEM THE PROBLEM OF SUBSTANCE ABUSE

ISSUE SUMMARY

SUBSTANCE ABUSE IS A PERVASIVE PROBLEM IN NEW JERSEY, AND TODAY IT PROBABLY AFFECTS MORE CHILDREN AND YOUTH THAN ANY OTHER SINGLE PROBLEM. BUT, A STATEWIDE POLICY HAS NOT BEEN ESTABLISHED TO ADDRESS THE PROBLEM, AND AFFECTED CHILDREN, YOUTH AND FAMILIES DO NOT HAVE ACCESS TO A CONTINUUM OF PREVENTIVE AND REMEDIAL SERVICES.

- 300,000-350,000 New Jersey youth (aged 12-17) use or abuse alcohol and other drugs.
- An estimated 62,000 New Jersey teenagers are problem drinkers and 54,000-62,000 use marijuana daily.
- Multiple and combined use of alcohol and drugs was reported by over 36 percent of New Jersey high school students surveyed in 1983.
- An estimated 20-40 percent of New Jersey children live with a parent who abuses alcohol or other drugs.
- 38 to 65 percent of child abuse cases are alcohol related.
- Children of alcoholics have higher rates of suicide, depression and substance abuse.
- Nearly 600 infants are born each year with Fetal Alcohol Syndrome or Fetal Alcohol Effects in New Jersey.
- Nationally, alcoholism is the fourth leading cause of death.
- Substance abuse costs society about $70 billion a year in lost productivity, health care costs, crime and accidents.
- Due to factors such as a lack of training of professionals and educators, substance abuse is often not diagnosed. Further, the effects of parental substance abuse upon children often go unrecognized.
- Many different state and local agencies are responsible for addressing problems related to substance abuse but joint planning has not been done to formulate a coordinated statewide strategy.
- There are inconsistencies in how the problem of substance abuse is handled by communities and

schools. Some focus on intervention to help the young person, while others focus on punishment.

- Prevention efforts are very limited in scope, and they are not in proportion to the severity and dimensions of the problem.
- State law mandates that the schools provide preventive education, but not all schools have complied with the law. The quality of the programs that are being provided varies considerably, and some are of very questionable effectiveness.
- Early identification and early intervention programs can avert young people from chronic addiction, but few such programs have been established.
- Few treatment programs exist in New Jersey for young people who are substance abusers or victims of problems resulting from parental substance abuse. Large numbers of New Jersey youth who require treatment must go to other states to receive services.
- Few after-care programs and transitional living facilities have been developed for young people who successfully complete residential treatment programs.
- A comprehensive strategy for the prevention and treatment of Fetal Alcohol Syndrome has not been implemented in New Jersey.
- Medicaid coverage and private insurance coverage are inconsistent for alcohol and drug treatment. Medicaid covers drug treatment but only covers alcohol treatment in demonstration projects. Private insurance coverage is mandated for alcohol treatment but does not cover drug treatment.

RECOMMENDED ACTIONS

I. STATEWIDE POLICY FOR BROAD-BASED PREVENTION AND TREATMENT

The Governor should initiate a statewide policy for the development of a broad-based, coordinated effort to prevent, assist and treat children, youth and families affected by substance abuse. Prevention and early intervention programs should be given equal priority with treatment services in the development of policy and programs.

II. STATEWIDE MECHANISM FOR COORDINATED PLANNING AND IMPLEMENTATION OF SERVICES

An on-going statewide mechanism should be established to coordinate the work of the different state departments **and** community agencies in planning and implementing prevention, early intervention and treatment services for children and youth affected by their own or parental substance abuse. This mechanism should:

1. **Include in its membership:**
    - The directors of the Division of Alcoholism and Narcotic and Drug Abuse Control of the Department of Health.
    - Representatives of the Department of Education units responsible for prevention and early intervention programs in the schools.
    - Representatives of the Divisions of Youth and Family Services, Mental Retardation, and Mental Health and Hospitals of the Department of Human Services.
    - Representatives of these other state government units: the Departments of the Public Advocate, Corrections, Community Affairs, Law and Public Safety and Labor, and the Administrative Office of the Courts.
    - A representative of the state Youth Services Commission.
    - Representatives of community groups and local agencies who work with children and families affected by substance abuse, and experts in the fields of prevention and treatment.
2. **Maintain close linkages** with county level planning groups which specifically address the problem of substance abuse such as the county Councils on Alcoholism, and maintain linkages with other state and county level planning groups which address youth needs.
3. **Function as a special committee** of the new Governor's Commission for Children and Youth with responsibility to prepare recommendations to the Commission on at least an annual basis for state action to improve services for the prevention, early intervention and treatment of substance abuse.

III. STATEWIDE PREVENTION AND EARLY INTERVENTION EFFORTS

A. STATEWIDE PLAN

Through the special committee of the Governor's Commission on Children and Youth, a statewide plan for prevention and early intervention efforts should be developed and modified as needed on an annual basis. This plan should include efforts addressing substance abuse among young people as well as efforts to ameliorate the problems resultant from parental substance abuse, including Fetal Alcohol Syndrome. The plan should also incorporate the additional recommendations for action reported here.

B. ESTABLISHMENT OF A NEW PREVENTION OFFICE

The Department of Health should combine the preventive efforts of the Division of Narcotic and Drug Abuse Control, which are non-methadone maintenance oriented, with the preventive efforts of the Division of Alcoholism. This new office, the Office of Alcohol and Drug Dependency Prevention should:

1. Be a central resource for all state, local and voluntary agencies which deal with children and their families, functioning as a Clearinghouse and Data Bank.

2. Have as its initial and primary focus, the population under 21 years of age.
3. Develop and implement strategies to focus on the family as a unit.
4. Have written agreements with all state departments and divisions that deal with children, youth and families as well as special contracts with each county.
5. Have designated liaisons with each major state department and county to meet regularly, coordinate, evaluate and provide assistance in preventive efforts.
6. Report to the special Committee of the Governor's Commission for Children and Youth on a regular basis, cooperating with the Committee's statewide prevention efforts.

IV. SCHOOL-BASED EFFORTS

A. UNIFORM GUIDELINES

The Department of Education should ensure that the local school districts adopt and utilize uniform guidelines to provide prevention and early intervention services for:

1. Substance abuse among students.
2. Services for children and youth at risk because of parental or sibling substance abuse.
3. Staff problems related to substance abuse.

B. PREVENTIVE EDUCATION, STUDENT ASSISTANCE AND EMPLOYEE ASSISTANCE

The Department of Education should also ensure that local school districts:

1. **Educate students** grades K-12 on substance abuse, including the effects of parental substance abuse, through implementation of approved curricula which meets already existing state mandates.
2. **Provide student assistance services and constructive intervention** in accordance with the intent of P.L. 1983, Chapter 531, for students who manifest substance abuse related problems affecting performance in the school setting. The local school districts should be required to utilize less drastic alternatives before excluding a youth from school. The program, which should also address the needs of children affected by parental substance abuse, should include:
    - Staff training and development.
    - Educational awareness.
    - Procedures for a system of referrals of youth for intervention and treatment services.
    - Development of support groups for youths who are recovering substance abusers.
    - Development of support groups for children and youth who live with a substance abuser.
    - Programs utilizing peer leadership to educate and assist other students.
3. **Incorporate Substance Abuse Counselors into the school system to implement curricula, provide counseling services, and develop as well as implement programs.** These counselors should be certified by the New Jersey Alcoholism Certification Board and meet appropriate requirements developed by the Department of Education.
4. **Provide an Employee Assistance Program for school personnel** affected by substance abuse. At minimum, the program should include a mechanism for the referral of staff to treatment services. Teacher representative groups should be encouraged to participate in the development of the program.

C. EVALUATION

The Department of Education shall develop and implement criteria for the evaluation of the quality of these programs to ensure parity of services, regardless of the district in which a student resides.

D. PROGRAM ASSISTANCE

The Department of Education shall offer the Districts program assistance in conjunction with the Department of Health in the development of the programs outlined here for both students and employees when:

1. A District's substance abuse program is deemed inadequate by the Department of Education.
2. A District requests aid.

V. TRAINING OF PROFESSIONALS

A. **School personnel:** Training for school administrators and teachers should include education for the identification of substance abusers and the identification of children at risk because of substance abuse within the family situation. Mandatory training should be included in the curriculum for teacher certification. In-service training should be required for those personnel who have already been certified.

B. **Health Care and Mental Health Professionals:** Training in the identification, treatment and effects of substance abuse should be made mandatory for the certification and licensing of health care and mental health professionals.

Professionals licensed to practice in New Jersey should be required to demonstrate competency before licensing. Such professionals should include but not be limited to:

- Physicians
- Psychiatrists

- Clinical Psychologists
- Counseling Psychologists
- School Psychologists
- Social Workers
- School Nurses
- Pharmacists
- Registered and Practical Nurses
- Other professionals in the practice of psychotherapy

VI. PUBLIC EDUCATION

The Departments of Education, Health and Human Services should be directed to develop a public education program involving local schools, community agencies, community groups and the media in:

A. **Training parents to recognize patterns of substance abuse** in young people, and educating them on intervention.

B. **Informing the public of the incidence and effects of parental substance abuse** on children in their care, and early intervention strategies to protect vulnerable children.

C. **Informing the public of the risk and effects of Fetal Alcohol Syndrome and Fetal Alcohol Effects.**

VII. TREATMENT

A. **Continuum of Services:** The special Committee on substance abuse should develop a plan for the development of a continuum of treatment services for youth who are substance abusers. The continuum should be designed to tailor services to the individual needs of the youth and to provide services in the least intrusive and least restrictive manner necessary. The continuum should include programs for youth who are abusing more than one substance and should consist of but not be limited to these types of services:

  - Out-patient treatment
  - Out-patient care services
  - Residential care
  - After-care
  - Transitional living facilities
  - Host homes for youth who cannot return from treatment to their own homes

B. FUNDING

The state should provide a minimum of $10 million for the development of this new continuum of services. According to the Department of Health, $10 million would support the development of sufficient services to reach 3,500 youth over a 30 month period.

C. STUDY EFFECTIVENESS OF HAVING SEPARATE UNITS

The Office of Management and Budget and the Department of Health should be directed by the Governor to conduct individual studies of the effectiveness of the current separation of the Division of Alcoholism and the Division of Narcotic and Drug Abuse Control. These studies should focus on efficient utilization of fiscal resources by each Division, maximization of the state's ability to develop an appropriate continuum of services for youth who are multi-abusers and efficient utilization of funds in order to implement such services.

D. MEDICAL INSURANCE AND MEDICAID COVERAGE

Medical Insurance and Medicaid Coverage for Both Drug Treatment Services and Services for Alcohol Abuse-Related Problems: Private insurance providers should be mandated by law to provide coverage for drug treatment services and Medicaid coverage should be provided for drug treatment services regardless of the age of the client. Further, Medicaid should expand its coverage to include treatment services for alcohol abuse related problems for all those who are Medicaid eligible.

VIII. STATEWIDE PLAN TO ADDRESS FETAL ALCOHOL SYNDROME

The Department of Health should implement a statewide plan for the early identification and treatment of children at risk of Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Effects (FAE). That plan should include:

A. Educating physicians to identify and intervene with pregnant women who are abusing alcohol.

B. Standard criteria for medical evaluation of infants and children suspected of suffering from FAS or FAE.

C. Steps for smooth coordination of medical, developmental, psychosocial, educational and alcoholism treatment services for affected children and parents.

D. Development of a directory of appropriate resources and services for prevention and treatment of FAS/FAE.

E. Maintenance of a data collection system as part of the Special Child Registry to gather data on the incidence of birth defects resultant from maternal alcohol or drug use and abuse.

THE JUVENILE JUSTICE SYSTEM AND THE FAMILY COURT: DEVELOPING PREVENTIVE SERVICES AND COST EFFECTIVE ALTERNATIVES FOR TROUBLED CHILDREN, YOUTH AND FAMILIES

ISSUE SUMMARY

ANNUALLY, OVER 90,000 DELINQUENCY COMPLAINTS ARE FILED AGAINST NEW JERSEY YOUNG PEOPLE, AND ABOUT 11,000 YOUNG PEOPLE ARE BROUGHT BEFORE THE COURTS ON NON-CRIMINAL MATTERS WHICH OFTEN STEM FROM FAMILY PROBLEMS. THE NEW FAMILY COURT SYSTEM PROVIDES AN OPPORTUNITY TO PROMOTE A COMPREHENSIVE APPROACH TO THE PROBLEMS OF TROUBLED CHILDREN, YOUTH AND FAMILIES BY UTILIZING NON-JUDICIAL INTERVENTIONS WHEREVER POSSIBLE TO DIVERT THEM FROM THE COURTS. BUT, FEW PREVENTIVE AND COMMUNITY-BASED PROGRAMS HAVE BEEN DEVELOPED TO ADDRESS THE NEEDS OF THESE CHILDREN AND FAMILIES.

- Large numbers of New Jersey's children and youth are brought into the juvenile justice system at an enormous cost to the state's taxpayers.
- Over 100,000 children and youth are arrested each year; only 5 percent of the arrests are for violent crimes.
- Many youth are at risk of becoming involved with the juvenile justice system.
  - —An estimated 44 percent of the 780,000 young people between the ages of 12-17 years abuse drugs or alcohol.
  - —Over 84,000 children in grades 5-12 are suspended annually from New Jersey's public schools.
  - —An estimated 50 percent of the high school students in urban areas drop out of school.
  - —The unemployment rate of New Jersey youth is 20.4 percent and in major urban areas the rate is estimated at 60 percent.
- Thousands of young people reach the juvenile justice system without ever having received preventive services.
- Services for troubled children and youth are actually diminishing as a result of a decline in federal support for these programs.
- While the new Family Court and the new juvenile-family crisis intervention units are promising initiatives, insufficient funding is available to develop ancillary services such as family counseling, treatment for substance abuse and specialized job training programs.
- Surveys of juvenile justice system personnel indicate that many of the complaints brought to the attention of the courts could be diverted if suitable community-based services were available for the young person and her/his family.
- Comprehensive planning has not been done at either the state or county level to develop and coordinate services for troubled children and youth.
- Studies show that county detention centers are being used for children and youth who could be handled in other less costly and less restrictive programs.
- The absence of community resources has led to an inordinate reliance upon correctional commitment for youth who could be handled in non-correctional programs. The majority of the youth who are incarcerated are very troubled young people who do not require secure custody measures.
- Current funding patterns promote over-reliance on costly institutional care for troubled youths.
- The Department of Corrections has developed alternative programs which cost an average of $10,000 annually per youth as compared with an annual cost of between $18,000-$24,000 for institutional care. While these programs have proven to be both more effective and less costly to operate than institutions, strong state support has not been provided for the establishment of additional alternative programs.
- National standards and regulations in other states prohibit use of extended isolation to punish youths for violation of institutional rules. However, in New Jersey correctional facilities extended isolation is often used and youth may be placed in solitary confinement for as long as 30 days.

RECOMMENDED ACTIONS

I. STATEWIDE POLICY: MAXIMUM PREVENTION IN LEAST INTRUSIVE MANNER

The Juvenile Justice system and related community support agencies should function as a broad system for "youth in trouble," i.e., youth experiencing family difficulties or conflicts with the law. This system should emphasize maximum prevention and provision of assistance to youth and their families in the least intrusive manner possible.

The broad Juvenile Justice system can be viewed as having six major levels of organization: (1) local police adjustments, (2) juvenile-family crisis intervention unit, (3) court intake, (4) formal adjudication and disposition, (5) probation or supervision, and (6) incarceration or residential placement.

All possible attempts must be made to prevent youth from moving to a more intensive/intrusive level in this system regardless of the level of penetration into the system or the extent of prior efforts to assist the youth. The policy of the State of New Jersey should be: **No youth should be placed in a restrictive facility (regardless of auspices) solely because of a lack of appropriate alternative services.**

To implement this policy, the committee recommends new community-based services, developed through better planning using additional state resources.

II. DEVELOP NEW COMMUNITY-BASED SERVICES

Top priority for planning and funding should be given to new and innovative community-based programs and services at the major pre-adjudicatory levels which are specifically designed to prevent the youth's further penetration into the Juvenile Justice system. Special emphasis should be placed on programming for delinquency-prone youth. These services should include: specialized education programs, family counseling, programs geared to individual development, environmental programs, mental health services, job development and training, and treatment for substance abuse. These services may also include programs providing for the assessment and treatment of youth charged with sex offenses.

Full implementation of this prevention policy cannot ignore those youth who reach more intrusive levels of this system. Innovative programs, including a network of nonresidential community-based services, must be created to encompass youth from all these levels, including those juveniles who come before the Youth Advocacy Project teams. Further, a delinquent offender should not be precluded from using pre-adjudicatory services.

III. COUNTY AND STATE PLANNING

A. **A county Youth Services Commission should exist in every county to serve as the comprehensive planning mechanism to implement this policy.** In order to effect this, P.L. 1982, Chapter 80, Section 16, should be amended to require that:

1. A Youth Services Commission (YSC) be established in every county to perform this planning function.
2. The YSC membership include: Freeholder, County Executive/Administrator, Presiding Family Court Judge, Family-Part Case Manager, Prosecutor, Chief Probation Officer, Public Defender, District Office Manager of DYFS, Mental Health/Human Services Administrator, County Superintendent of Schools, Director of Youth Shelter, Director of Detention Facility, Director of the Juvenile-Family Crisis Intervention Unit, President of the Chiefs of Police Association, President of the Juvenile Officers Association, Member of the Private Industry Council, representatives of the state departments of Human Services and Corrections, and youth members. The county may choose to appoint additional members including but not limited to representatives of private community-based organizations and volunteer and child advocacy groups such as Juvenile Conference Committees, Child Placement Review Boards and Volunteers in Probation.
3. The Commission be chaired or co-chaired by a Freeholder, County Executive/Administrator or the Presiding Judge of the Family-Part of the Superior Court.
4. State funding be made available at a level of $500,000 annually for the 21 YSCs, with the specific allocation of each county to be determined by category of county and the county share of costs for staffing of the county YSC.
5. Each county YSC be charged with the following responsibilities:
   a. Annually prepare and submit to the Department of Human Services through the County Board of Freeholders a **need-based plan** prioritized according to high-risk population and high-risk geographical areas within the county.
   b. **Coordinate and integrate existing services** for troubled youth noting gaps in service delivery.
   c. **Develop new and innovative programs** to meet the needs in service gap areas.
   d. **Develop an on-going mechanism** that would determine the extent of juvenile offenses and related juvenile problems and determine geographic locations where juveniles are at greatest risk within the county.
   e. **Develop and coordinate the efforts of municipal and regional** Youth Services Commissions within the county.
   f. **Inform the public** of the nature and extent of the problem, availability of services and other juvenile justice issues.
   g. **Advise** the Family-Part Case Management Team in its planning effort.
   h. **Participate** with representatives of the Department of Human Services in monitoring the implementation of the Family Court plan.
   i. **Maintain relationships** with county human services advisory councils, county alcohol citizen advisory committees, county mental health boards, etc., **in order to maintain coordinated planning** for services and to advocate for the needs of this high-risk population before these groups.

B. **A permanent state-level mechanism should exist to address planning and coordination issues related to the state's Juvenile Justice system and to address those issues raised by the county Youth Services Commissions.** The proposed Governor's Commission for Children and Youth (GCCY) should, once it has been established, provide for the on-going facilitation of this mechanism as part of the GCCY's comprehensive planning role. Further, in light of the work already done by the state Youth Services Commission, the state YSC should function as the Juvenile Justice planning mechanism within the context of the GCCY's broad planning effort.

1. **Role**

   The role of the Juvenile Justice planning mechanism should include:

   - **Coordination of activities** between county and state representatives to develop plans for a program utilizing fiscal incentives to encourage the counties to establish county-based alternatives to incarceration for youth adjudicated delinquent for nonviolent offenses, and
   - **Provision of assistance in developing a minimum information system** supported by state funds (in whole or in part) to provide reliable data for the purposes of planning, budgeting, monitoring, program review and assessing the extent to which state priorities are being realized. The information gathered will be of use to all programs serving high-risk youth.

2. **Membership**

   Membership should include high-level staff from each of the participating state departments and the Administrative Office of the Courts as well as representatives of juvenile justice advocacy groups and provider agencies.

3. **Staffing**

   At least one full-time staff person should be provided by the GCCY for the work of the Juvenile Justice planning mechanism.

IV. PROVIDE ADDITIONAL STATE RESOURCES

A. **Through the Department of Human Services, the State should appropriate on an annual basis $6.5 million for use by the counties to develop and implement the new and innovative services for youth planned by the YSCs.** These new funds should not be used to supplant funds for existing programs. Each county should be required to submit for approval to the Department of Human Services an annual plan that has prioritized its share of this funding to maximize service delivery to the county's own high-risk population and high-risk geographic areas. This allocation should not preclude a county from competing for other monies or from pooling resources with other counties to develop programs for a target population. Of these funds:

1. The majority should be allocated among the 21 counties on a per capita basis for the population group aged 10-17 years of age.
2. The remainder should be distributed to those counties exhibiting such high-risk factors as measured by: rates of arrest, excluding status offenses; rates of social and family disruption; numbers of families with incomes below the poverty level; rates of youth unemployment; and school drop-out rates.

B. **The state should also provide $520,000 annually to establish, under the auspices of the Department of Corrections, Youth Advocacy Projects in all 21 counties.** These projects, modeled after the Youth Advocacy Project initiated by the DOC, should be required to:

1. **Review detention center admissions** on an annual basis to survey the characteristics of the children admitted to these facilities on a pre-adjudicatory basis, and to determine the extent to which the facilities are being used for children who do not require secure confinement. The findings, which shall be reported annually, shall specify the particular alternative services needed for these children.
2. **Develop multidisciplinary teams to review the case of every youth adjudicated delinquent and about to be committed to DOC** to determine, prior to the youth's actual physical commitment to DOC, whether the dual purposes of protection of the community and rehabilitation of the youth could be more effectively achieved by the provision of alternative services. In each case where the team finds that alternative services are appropriate, the team shall specify what services are needed.

   The findings of the team shall be reported annually and shall include a statement indicating:

   - Number of youth reviewed, number for whom alternative services were appropriate,
   - Number for whom alternative services were arranged; and
   - Number of youths physically committed to DOC.

   The report shall also indicate specific service gaps identified by the team and the team's recommendations for the development of additional alternative services.
3. **Develop individualized services plans**

for youths adjudicated delinquent to provide them with necessary rehabilitative services and supervision within the community.

4. **Recommend, based upon the findings of its review, priorities for the development of alternatives** to secure detention and incarceration on an annual basis to its County Youth Services Commission.
5. **Cooperate with an evaluation** of the project at year three to be conducted by the state juvenile justice coordinating mechanism.

V. COST-EFFECTIVE ALTERNATIVE PROGRAMS FOR JUVENILES COMMITTED TO THE JAMESBURG TRAINING SCHOOL

In light of the increasing recognition by the DOC that the rehabilitation and education of juvenile offenders can be more effectively accomplished in small, decentralized facilities/programs capable of responding to the individual needs of particular offenders, a strategy for initiating more alternatives for committed youth should be conceived and implemented.

The Department of Corrections should conduct a study of the feasibility of developing more such alternative facilities/programs for all of the youth now being sent to the Training School for Boys at Jamesburg. The findings should be reported to the Governor's Commission for Children and Youth.

This assessment should include:

- Identification of youths who could be served in alternative programs.
- Description of the types of alternative programs which would be required to provide proper supervision and services for the youth.
- An estimate of the resources required to develop alternative programs.
- An estimate of the initial and continuing resources necessary to transfer youths to, and operate these alternative programs.
- A comparison of the costs of the new programs to the existing programs at Jamesburg.
- Plans to interface with other state departments to develop programs geared to positive youth development.
- Plans to allocate a fair proportion of resources to the provision of services and programs for girls adjudicated delinquent.

VI. REVIEW USE OF ISOLATION

Plans for the construction of the proposed isolation unit at the Jamesburg Training School for Boys should be halted until a thorough review of the appropriateness of plans has bean conducted. That review should include an assessment of existing practices concerning the use of isolation, consultation with experts from other states regarding the effectiveness of using isolation as well as information on other methods of minimizing disruptive behavior among young offenders, and an evaluation as to the specific physical and programmatic designs that could be utilized at the Jamesburg Training School with a decreased population and/or for alternative programs to deal with disruptive behaviors in a constructive manner.

Council of the Arts

ACTION TO IDENTIFY AND MEET CHILDREN'S NEEDS: A VOICE FOR CHILDREN

TEXT—CHAPTER VI

State government alone cannot fully address all the needs and problems reported here. It can, however, provide leadership for vigorous public sector, private sector and community action to assure that the most critical needs of New Jersey's children are identified and met on an on-going basis.

This Chapter reports the Governor's Committee's recommendation to establish a mechanism to provide a voice for children in the state planning process, facilitate coordination among the agencies serving children, and build cooperative efforts between the public and private sectors.

BUDDING TREES
HUMAN SKELETON
USIC

Neighborhood Information Services, Newark, NJ, Al Jeffries, Photographer

ISSUE SUMMARY

NO MECHANISM CURRENTLY EXISTS WITHIN STATE GOVERNMENT TO ASSESS CHILDREN'S NEEDS FROM AN ORGANIZATIONALLY NEUTRAL PERSPECTIVE, AND TO SERVE AS A NEUTRAL VOICE FOR CHILDREN IN THE OVERALL PLANNING PROCESS. CHILDREN'S NEEDS ARE OFTEN OVERLOOKED OR GIVEN LOW PRIORITY DESPITE THE EFFORTS OF INDIVIDUAL STATE GOVERNMENT UNITS, AND AVAILABLE RESOURCES ARE NOT CONSISTENTLY COORDINATED.

- A statewide agenda for children is not established on a regular basis to guide policy and program development.
- A statewide inventory of services is not maintained to provide a picture of who is getting what services at what cost.
- There is no clearinghouse to facilitate communication among the three branches of government and to provide community groups with information about programs.
- There is no neutral entity to facilitate resolution of coordination issues and service delivery problems that involve the operations of different units of state government.
- Consistent support is not provided for broad prevention efforts.
- Conflicting policies arise about the same issue.
- Critical needs go unmet.
- Broad community and private sector support have not been developed for children's services.
- Planning is reactive rather than proactive.

RECOMMENDED ACTIONS

I. ESTABLISH GOVERNOR'S COMMISSION FOR CHILDREN AND YOUTH

A. The state should establish a "Governor's Commission for Children and Youth" to promote the development, provision and coordination of those services necessary to strengthen families and assure every child the opportunity to develop to her/his full potential.

B. The Commission should be designed to involve both community members and public officials in:

- **Evaluation and Needs Assessment** to identify the needs of children and families; assess the adequacy of current provisions to meet the needs; and to identify major service delivery problems.
- **Planning to Set Priorities on a Statewide Level** for: allocation of resources for children; action to eliminate service gaps and duplication in services; and action to resolve broad systems problems.
- **Providing Centralized Support and Technical Assistance to Facilitiate Cooperative Efforts** among state departments and between state departments and local groups to develop needed services and eliminate service delivery problems.

C. The Commission should also address the needs of youth and should be required to foster a broad range of prevention efforts aimed at positive youth development.

II. ENABLING LEGISLATION

The Commission should be established by bi-partisan legislation with a clause requiring a review of the effectiveness of the mechanism following its first five years of operation. This will assure the continuity of the mechanism while at the same time provide formal review and modification if necessary. The enabling legislation should mandate the following structure, functions and responsibilities:

A. Membership: Citizen-chaired group jointly appointed by the Governor and the Legislature. The Commission should include a minimum of 15 public members knowledgable of children's issues and representative of the different population groups within the state. The Commission should also include the Commissioners of the Departments of Community Affairs, Corrections, Education, Health, Human Services, Labor, and the Public Advocate. Further, the Chief Justice of the Supreme Court should be invited to sit on the Commission. Additionally, the membership should include the Director of the Office of Management and Budget and representatives of both the Senate and the Assembly. The Commission may also request that other state government coordinating committees/councils appoint representatives to sit ex-officio on the Commission and its sub-committees.

B. Mandated Scope: The mandate should enable the Commission to evaluate children's needs and to assist with the planning and coordination of a broad range of services including but not limited to: Health, Education, Social Services, Juvenile Justice, Mental Health, Youth Employment, Early Childhood Development and Economic Security. The mandate should also authorize the Commission to undertake activities to facilitate a broad range of prevention efforts to foster positive youth development.

C. Location in State Government: Established as a separate entity, functioning apart from any state department unit which provides services for children. The mandate should require the Commission to carry out its responsibilities from a neutral framework, not bound by the priorities of any single state agency.

D. Reporting Responsibilities: Required to work with and report to the Governor, the Legislature and the Judiciary.

E. Functions, Responsibilities and Authority:

To carry out its role in evaluating needs, setting priorities for action and facilitating cooperative efforts, the Commission's mandated functions and responsibilities should include:

1. **Functions:**
    - Develop, on an annual basis, **a statewide agenda for children** specifying goals and objectives to guide priority selection and resource allocation.
    - Maintain a **mechanism for data collection and analysis** on a statewide basis to provide data for needs assessments and planning. This mechanism shall include the statistical data reported annually by all other advisory and coordinating bodies established by either executive order or legislation to address issues affecting children.
    - Maintain an **overview of the children's services system as a whole,** with an up-to-date inventory of programs, services, number of persons served and expenditures.
    - **Facilitate communication and cooperation** among the many different agencies and community groups who are interested in providing services for children.
    - **Improve procedures for evaluating children's needs** and planning services for children, thereby reducing gaps/duplications in services.
    - **Facilitate coordination** among state departments **and** between state and local agencies (county and municipal).
    - **Foster increased awareness** of children's needs and critical children's services issues.
    - **Facilitate broad prevention efforts** at the state and local level to foster positive youth development.
    - **Stimulate increased private sector/community involvement** in planning **and** supporting services for children.
2. **Required to:**
    - Establish and **maintain an information system** that cuts across program and department boundaries to gather data required for: a statewide inventory of services; a "picture" of persons served; needs assessments; and reporting of actual expenditures.
    - On an annual basis, **prepare recommendations** for the Office of Management and Budget and the Legislature for state budget priorities for children. Provide additional recommendations as needed during the overall budget process.
    - **Maintain a "clearinghouse"** to provide the three branches of state government and the community with information on available programs, services and resources. This "clearinghouse" shall also include an inventory of innovative approaches to foster positive youth development.
    - **Advise the Governor** of coordination problems amongst the state departments, propose methods to resolve them and facilitate planning groups to address specific coordination issues.
    - **Cooperate with public and private agencies** in the development of programs and services for children.
    - **Annually prepare an evaluation of the needs of New Jersey's children, and report to the Governor, the Legislature and the Judiciary** on the status of children and children's services. This report shall include the Commission's recommendations for a statewide agenda for children.
3. **Authorized to:**
    - **Hold public hearings** to gather information about children's needs and service issues.
    - **Conduct studies** on specific issues affecting children.
    - Obtain and **review the annual plans** and budgets of the state departments, and assist in the development of the annual budgets.
    - **Convene meetings** among state officials and between state officials and community members to formulate recommendations to address specific unmet needs and/or to resolve service delivery problems.
    - **Establish such sub-committees and ad hoc groups as are required** to improve the planning and coordination of services for children.
    - **Provide technical assistance** to support the efforts of other state and local bodies involved in the planning and coordination of services for children.
    - Take all actions necessary and proper to carry out the provisions of the enabling legislation.
    - Seek grant funding from private foundations and the federal government for research and other activities.

F. **Resources and Funding:** Provide staff who have a broad knowledge of children's services issues and direct experience in the planning, provision and coordination of services within the state government framework. Staff should also have skills in policy analysis, planning, research, data collection/analysis; public information/community relations; and prevention efforts.

Resources should be provided for the design and operation of a statewide information system. Provision should also be made for reasonable expenses connected with the work of the Commission, including costs for basic office equipment and travel costs incurred by Commission members in the course of their official duties.

Funding should be provided on an annual basis by a separate line appropriation specifically earmarked for the work of the Commission.

Developmental Disabilities Council

I.

New Jersey Department of Human Services

A COMMITMENT TO CHILDREN: NEW POLICY AND PROGRESS

Governor Thomas H. Kean, in establishing this Committee, set forth the policy that:

> **NEW JERSEY'S CHILDREN SHOULD BE AFFORDED THE OPPORTUNITY TO DEVELOP TO THEIR FULLEST POTENTIAL AND, IN ORDER TO FURTHER THIS DEVELOPMENT, PROBLEMS CONFRONTING CHILDREN AND THEIR INDIVIDUAL NEEDS SHOULD BE EFFECTIVELY ADDRESSED BY STATE AND LOCAL GOVERNMENT.**[1]

This broad policy, which is essentially a statement of **commitment to meeting the basic needs of children,** serves as the foundation for the recommendations of the Committee. In order to establish specific priorities for action, the Committee first identified those basic needs of children **and** families which must be met to assure children the opportunity for healthy growth and development. The Committee then reviewed the adequacy of existing provisions to meet those needs which include:

- **Basic Foundations for Life**
  - **Economic Security** as measured by sufficient income to provide for minimal essentials such as food, shelter and clothing.
  - **Health Care,** including prenatal care and preventive services through childhood.
  - **Housing,** that is safe, decent and affordable.
  - **Quality Education** that provides the individual child with a full opportunity to develop to her/his maximum potential.
- **Access to a Full Range of Preventive and Supportive Services** Which Strengthen the Family's Ability to Care for the Child, and Which Assure that Children Are Protected From Harm Damaging to Their Physical, Emotional and Intellectual Development.
- **Access to a Full Range of Therapeutic and Rehabilitative Services** For Problems Such as Mental Illness, Substance Abuse and Delinquency in the Least Restrictive Mode Necessary.

SELECTING PRIORITIES FOR ACTION

In recent years, the state has established a broad range of policies and programs designed to meet the basic needs of children and families. As the Commission on Children's Services found, at least 14 state departments and 26 different divisions administer funds and programs for children and families. Additionally, thousands of local, public and private agencies provide services for New Jersey's children and families.[2]

However, as the Commission reported in **Linking Policy with Need,** certain broad systemic problems impede the planning, coordination and provision of programs to meet the needs of children and families. These broad systemic problems have led to inefficiencies and inequalities in how the state's resources are used to meet pressing human needs.[3] The Commission also found substantial gaps in services which cause many children to go without critically needed assistance for problems damaging to their physical and emotional well-being.[4]

In the course of its work, the Governor's Committee focused on those systems issues and critical service gaps that still exist. In selecting its priorities for action, the Committee narrowed the scope of its work to those problems which pose the most risk of harm to children and used these criteria as a guide:

- The number of children affected by the problem
- The short and long term harm to children
- Whether there are other on-going efforts to address the issue

A summary of the issues identified is reported in Chapter II, and those chosen as priorities for action are detailed in Chapters III, IV, V and VI. Some very critical issues such as child abuse/neglect, infant mortality and adolescent pregnancy have not been singled out for specific action plans because plans are being developed by other major groups. There are, as well, many other issues which the Committee viewed as important but was unable to fully address because of time constraints.

MAJOR NEW INITIATIVES

While the Governor's Committee found that many serious problems continue to jeopardize the well-being of New Jersey's children, it also learned that, since the publication of **Linking Policy with Need,** numerous new initiatives have been undertaken to address the issues reported by the Commission on Children's Services. All three branches of government, local agencies and citizen groups have mounted significant initiatives, illustrating that there is a growing commitment to vigorously address the needs of New Jersey's children.

Following is a partial listing of the major new initiatives identified by the Governor's Committee:

EXECUTIVE BRANCH

- Three executive-level advisory groups have been established to develop strategies to alleviate these serious problems affecting children: Homelessness, Child Abuse and Mental Retardation.
- Through the **Office of Management and Budget,** a Strategic Planning Process has been im-

plemented to identify statewide needs and to guide resource allocation.

- A Juvenile Delinquency Disposition Commission has been appointed to assess the impact of the new Juvenile Code and to gather data on dispositions for youth adjudicated delinquent.
- The **Department of Corrections** has vastly expanded the range of alternatives to incarceration for young offenders, and established more than 10 new programs for troubled children.
- The **Department of Education** has begun to closely examine the resource deficiencies of the urban school districts and has established special projects to reduce the rates of drop-out and suspension. Also, D. of Ed. in conjunction with the **Departments of Health and Human Services**, has implemented a statewide program to provide Early Intervention Services for preschool handicapped children. Further, Family Life Education programs have been established in the local schools.
- The **Department of Health** opened 12 new programs to screen an additional 12,000 children for lead poisoning.
- The **Department of Human Services** has established a statewide Human Services Advisory Council to improve the process for planning social services. DHS has also re-organized the Division of Youth and Family Services to re-focus resources on preventive services for those families most in need, and to establish networks to unify services at the county level. Further, DHS has made a significant effort to increase the number of minority staff in administrative as well as service positions.
- A seven percent increase, the first provided in four years, has been granted in the benefit levels of the Aid to Families with Dependent Children program.

LEGISLATIVE BRANCH

- Legislation was enacted to revise the state's Juvenile Code, establish a Family Court system providing crisis intervention services for Juvenile-Family problems, extend the Child Placement Review Act, provide adoption subsidies for hard-to-place children, establish an Advisory Council on Child Care, create a Missing Person's Bureau, expand youth employment programs in the urban areas, provide emergency assistance for homeless families and improve the state's housing assistance programs.
- Legislation has been introduced to provide Medicaid coverage for poor children, screen children for lead poisoning, establish employer incentives to fund child care services, mandate the education of children in county facilities, prevent rental discrimination against families with children and establish a special fund for child protective services.
- Legislative hearings have been held on a number of issues particularly affecting children and families such as child abuse, unmet health care needs and the housing shortage.
- Appropriations have been provided to fund many important programs and services including a seven percent increase in benefit levels for Aid to Families with Dependent Children, as well as to fund major legislative initiatives cited above.

JUDICIARY

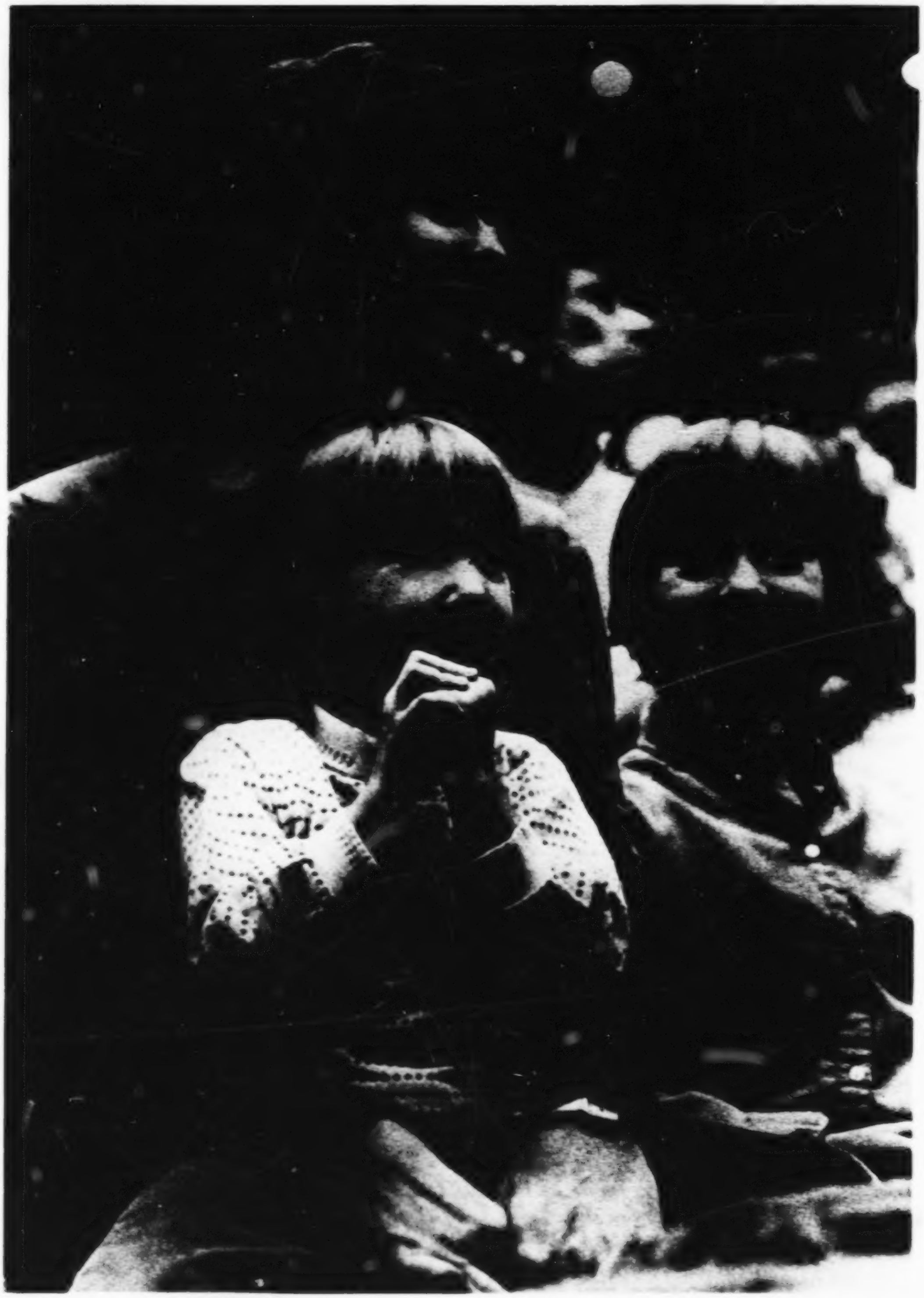
- The **Youth Services Commission,** established under the leadership of the Chief Justice of the Supreme Court, Robert N. Wilentz, has been bringing together representatives of public and private agencies to improve services for children in conflict with the law.
- The **Administrative Office of the Courts** (AOC) has been working to facilitate the implementation of the new Family Part of the Superior Court and to develop services linkages between the courts and social service providers. As part of this process, a **State Family Court Committee,** composed of citizens and judges, has been involved in planning the transition.
- The **Probation Services Division** of the AOC has initiated a series of innovative projects to improve services for juvenile probationers.

Additionally, a wide range of citizen groups have worked with local communities and state government to implement these initiatives. Those groups include: **Concerned Parents for Head Start; the League of Women Voters; the National Council of Jewish Women; the Junior Leagues of New Jersey; the New Jersey PTA; the National Committee for Prevention of Child Abuse—New Jersey Chapter; Puerto Rican Congress; the Mental Health Association in New Jersey; the New Jersey Foster Parent Association; the New Jersey Anti-Lead Poisoning Coalition; the Network on Adolescent Pregnancy; the New Jersey Association of Black Educators; the Association for Children of New Jersey; Parents Anonymous;** and **New Jersey Church Women United.** Citizens and services providers have also been working for change through participation on county **Youth Services Commissions,** county **Councils on Alcoholism,** county **Human Services Advisory Councils** and a diverse mix of professional organizations.

These efforts of public officials and citizens have alleviated some of the deficiencies in the planning, coordination and provision of services. However, many very pressing needs of New Jersey's children still are not adequately met or are not being met at all. A summary of those needs follows in the next chapter.

NOTES

1. Executive Order 35, March 14, 1983.
2. R. Alexandra Larson and Carol Kasabach, *Linking Policy with Need.* (Trenton, NJ: New Jersey Commission on Children's Services, 1982), chpt. IV.
3. *Ibid.*
4. *Ibid.*



II.

- Children Growing Up in Poverty
- Housing Shortages
- Health Care Problems
- Handicapped and Disabled Children
- Children of Children
- Growing Need for Child Care Services
- Educational Deficiencies
- Unemployed Youth
- Troubled Children and Families
- Increasing Family Violence and Child Abuse
- Substance Abuse
- Emotionally Disturbed Children
- Children in Conflict with the Law

Princeton Packet, Andrea Kane, Photographer

NEW JERSEY'S CHILDREN AND FAMILIES: CURRENT STATUS AND NEEDS

The Governor's Committee examined the current status and needs of New Jersey's 2.2 million children and 1.1 million families in order to develop a picture of the social and economic context for action. This chapter summarizes the information the Committee gathered about critical needs and problems, and it presents the highlights of key findings reported in subsequent chapters.

While the responsibility for meeting the needs of children rests primarily with the family, community and governmental support has become vital, particularly in light of sweeping socio-economic changes. As both the Commission on Children's Services and the U.S. House Select Committee on Children, Youth and Families have found, strong socio-economic forces are affecting families from all income levels.[1] Further, the evidence suggests that there are "greater pressures upon children, youth and families now than at any time in recent decades."[2]

In fact, the "scope and speed of recent social and economic change are of a magnitude unprecedented in our lifetime,"[3] and have created severe stresses for New Jersey's families.[4] Today, hundreds of thousands of New Jersey's children are growing up in situations damaging to them because their families cannot adequately provide for their basic needs. Most vulnerable are Black and Hispanic children whose families continue to bear the brunt of adverse socio-economic forces.

CHILDREN GROWING UP IN POVERTY

Poverty is perhaps the single most important problem facing New Jersey's children and families today. Nearly 148,000 families, or 7.6 percent of those in the state, have annual incomes below the federal poverty guideline.[5] Further, if the economic status of New Jersey's families is evaluated in light of the **actual cost of living** in New Jersey, the ranks of the poor are substantially greater. **Hundreds of thousands of the state's families do not have sufficient income even to meet minimal survival needs** as conservatively estimated by the National Social Science and Law Project.[6]

Nearly 400,000 of New Jersey's children are growing up in pronounced poverty. This means that at least one out of every six New Jersey children stands at high risk of serious deprivation, deprivation that results in nutritional deficiencies and health problems that may stunt the child's development. The odds against minority children are even greater. **About one out of every three minority children lives in poverty in New Jersey.**[7]

While many impoverished families receive assistance through the Aid to Families with Dependent Children (AFDC) program, the AFDC benefit levels have not kept pace with inflation and cover less than 60 percent of the minimum cost of living in New Jersey.[8] In fact, the AFDC benefit levels are more than 20 percent below the federal poverty guideline.[9] (See AFDC section of this report for additional details.)

As a number of studies have documented, increasing numbers of New Jersey families are being forced to make drastic choices among basic necessities as they cannot afford to meet all of their minimal survival needs.[10] Growing numbers of families are turning to emergency food centers, and **there is a new phenomenon of children who are growing up "chronically hungry."**[11] Many children are growing up without proper medical care and in unsafe housing situations.[12]

Social service agencies report a "growing sense of desperation and defeatist attitudes among children and families they assist."[13] Further, there are indications of a **"noticeable increase in family disintegration," attributable to the stresses of poverty.**[14]

HOUSING SHORTAGES AND GROWING NUMBERS OF HOMELESS

Statewide, there is an acute shortage of safe, affordable housing for families from all but the highest income brackets.[15] Currently, at least 120,160 new or rehabilitated housing units are needed for modest-income families living in inadequate housing and an additional 123,933 units will be needed during the next 15 years.[16]

Further, about one million New Jersey residents, **nearly 14 percent of the state's population live in substandard housing,** housing that often has serious structural deficiencies that expose the inhabitants to health hazards and risk of injury.[17] Many of these "inhabitants" are children, and many are very young children who are especially vulnerable to health problems and injuries resulting from unsafe and unsanitary housing conditions.

The grave risks to young children were documented in a 1984 study of the housing conditions of 551 low-income families of children enrolled in the Head Start program in Newark. This study found that 61 percent of the families had rats in their housing units, 90 percent had roaches and nearly 50 percent had other hazards such as peeling paint and leaking ceilings. The study concluded that "**(a)lthough public health pro-**

fessionals have long seen the connection between rat and roach infestation and flaking paint on the one hand, and disease and lead poisoning on the other, extremely large numbers of Newark children live in neighborhoods and housing units where these conditions are commonplace and unaddressed."[18]

New Jersey's housing shortage forces low-income families to make painful choices: to either live in deficient housing at a risk of harm to their children or spend a disproportionate amount of their income on better housing, thereby leaving themselves unable to meet the food and health care needs of their children.[19] Currently, more than 75 percent of New Jersey's 394,000 lower-income households are paying more than they can afford to rent shelter. Similarly, 69 percent or 200,000 of the lower-income families who own homes pay more than 25 percent of their gross income for housing costs.[20]

One of the most serious effects of the housing shortage is the **increase in the number of homeless families** and individuals, an issue identified by the Governor's Task Force on the Homeless.[21] Further, the lack of housing has been identified as a **major cause of family break-up** resulting in the need for foster home placement of children in New Jersey.[22]

HEALTH CARE PROBLEMS

Infant mortality rates in New Jersey, which had been steadily decreasing since 1960, rose 1 percent in 1982 to 11.7 per 1,000 live births.[23] Although the available data show a very slight decrease to a rate of 11.3 per 1,000 live births for 1983, the rates still remain higher than that reported for 1981 **and** higher than the national average of 10.9.[24] If the rates remain relatively constant, more than 1,100 infants will die this year in New Jersey.[25] Further, as is the pattern nationally, the infant mortality rate for non-white infants is more than double that for whites in New Jersey.

Over the years, there has been a consistent decrease in the rate of children born with birth weights below 5.5 pounds. Low birth weight infants are at higher risk of developmental delay, neurological impairment and mental retardation. It is estimated that in 1984, about 6,680 New Jersey babies, a rate of 6.6 per 1,000, were born with birth rates below 5.5 pounds.[26]

Despite gains in reducing the overall infant mortality rate and the rate of low-birth weight, there is still a **significantly higher risk for infants in New Jersey's urban areas.** Statistics for 1980 show that in nine major cities at least 30 percent of pregnant mothers did not receive prenatal care in the first trimester. In Atlantic City, over 50 percent did not receive adequate prenatal care, and the infant mortality rate for the city was more than triple that for the state. Similar patterns of markedly high infant mortality rates were noted for other cities such as Camden, East Orange, Jersey City, New Brunswick, Newark and Plainfield.[27]

Lead poisoning is a major cause of childhood illness and disability in New Jersey, and an estimated 220,000 preschool children are at high-risk of lead poisoning. Chronic lead poisoning causes serious neurological problems and learning disabilities, and can even result in mental retardation or death. However, in 1983-84 programs existed to screen only 35 percent of the children at high-risk of exposure.[28]

Through the state's Medicaid program, the Early Periodic Screening, Diagnosis and Treatment (EPSDT) service is available to provide **preventive health care** for impoverished children. This service is especially important for poor children who are at higher risk of illness and disabilities by virtue of the living conditions and nutritional deficiencies associated with poverty.[29] **However, New Jersey has one of the lowest rates of EPSDT utilization in the nation** and untold numbers of children may be receiving no or inadequate preventive health care services. In 1983, only 10.9 percent of the more than 330,000 eligible New Jersey children were screened.[30] (See Medicaid section of this report for additional details.)

Further, there are an estimated 100,000 New Jersey children from impoverished families who have not been given Medicaid coverage and may not be receiving any medical services because their families cannot afford to pay for them.[31] Under current state regulations, only those families who are poor enough to qualify for AFDC or receive Supplemental Security Income are granted Medicaid coverage. Thus, even families whose annual incomes are substantially below the federal poverty guideline do not qualify for Medicaid despite the fact that their poverty prevents them from purchasing health care services. (See Medically Needy section of this report for additional details.)

Even those children who do have Medicaid coverage are sometimes unable to receive necessary services. Because the rates of Medicaid reimbursement rates for ambulatory care do not cover the actual cost of providing services, many providers will not accept Medicaid.[32]

HANDICAPPED AND DISABLED CHILDREN

Many New Jersey children are born with or are later afflicted by handicaps and developmental disabilities which will impair their ability to become self-sufficient and require them to depend on life-long public assistance. In fact, currently there are an estimated 4,000 children under the age of three who have handicaps which, if untreated, will impede their long-term development.[33]

Further, an estimated 41,810 New Jersey children suffer from developmental disabilities as measured by impairment in at least three major life skill functions. Of these children, about 70 percent are the victims of severe mental retardation.[34]

New Jersey Department of Human Services

Additional untold numbers of New Jersey children experience developmental delays and learning deficits as a result of factors associated with poverty, insufficient early stimulation and inadequate educational services. While many of these children have substantial innate potential, their chances for developing that potential are blunted because they do not receive adequate developmental supports.

THE CHILDREN OF CHILDREN

Especially vulnerable to health care problems and other deficits that impede healthy development are babies born to teenage parents. Nationally, it is estimated that over one million teenagers get pregnant each year.[35] In New Jersey, an estimated 30,000 teenagers between the ages of 15-19 years become pregnant each year.[36] Further, in 1982 over 11,000 children were born in New Jersey to mothers between the ages of 10-19 years.[37]

The vast majority of these babies were born to unmarried girls. In many instances, these girls were ill-prepared for motherhood, had inadequate prenatal care and insufficient financial and emotional support to meet their babies' needs.[38] Few specialized services exist for this population of teen parents and children, and many of these new families become trapped into dependence on AFDC because the young mothers must leave school prematurely.[39]

Babies born to teenagers are at a higher risk of health problems and other disabilities associated with poor prenatal care and poverty. There are higher risks of infant death with these babies as well as an increased risk of low birth weight and complications during labor and delivery.[40] Further, studies indicate that children of teenage parents tend to be "less healthy, to be less adequate as parents, to achieve less academically and to repeat their parents' patterns.[41]

GROWING NEED FOR CHILD CARE SERVICES

In the wake of profound societal and economic changes, more mothers are working than ever before. Many of these are single parents who are working out of economic necessity. In New Jersey alone, single parent families headed by women represent about 55 percent of all the state's impoverished families.[42]

According to the Department of Labor, nearly one million New Jersey children have working mothers. However, despite a growing need for child care services to enable women to join the labor force, center-based child care services are available for less than 20 percent of these children. Further, little is known about the quality of care given the children of working parents and some receive no child care services at all.[43]

Recent estimates suggest that as many as 250,000 elementary school children in New Jersey are left alone while their parents are at work.[44] The numbers of these "latchkey" children are expected to grow during the next decade because affordable after-school programs are not available for them. Increasing numbers of parents are being forced, out of economic need, to forego child care services for their children because they do not have the ability to pay for them.[45]

While some pre-teens have the maturity to handle independence, other children do not fare well when left to supervise themselves. For these children, there are risks of accidents, molestation by adults, involvement in substance abuse and delinquent behavior, and emotional problems. The risks are particularly pronounced for children under 10 living in urban areas.[46]

EDUCATIONAL DEFICIENCIES

An adequate education is one of the most important tools by which a child can better her/himself and assure her/his capacity to earn a sufficient living. However, many New Jersey children are being deprived of the opportunity for an adequate education.

There are about 1.5 million school-age children in New Jersey today who are, by state law, entitled to an equal opportunity to a free public school education. But, the current formula for funding public school education had led to grave disparities in the quality of educational services for the state's children. Most affected are minority children, the vast majority of whom as clustered in the poorer urban school districts with the least resources for educational services.[47]

Thomas Benjamin, Photographer

School drop-out rates, which are, perhaps, a subtle measure of the failure of the educational system to meet the needs of certain students, range as high as 50 percent for high school students in the urban areas.[48] Further, drop-out rates are on the rise among minority students. Although minority students represent only 30 percent of the state's student enrollment, they represent over 41 percent of all drop-outs.[49]

Substantial numbers of children, many of whom have learning disabilities and emotional problems, are being suspended from New Jersey's schools. Since 1977, the number of children suspended from school at least once has exceeded 84,000 every year.[50] There are wide variations in school discipline and suspension practices, and Black and Hispanic children are more likely to be adversely affected. In 1982, Black and Hispanic children represented only 27 percent of the total student enrollment, but accounted for 37 percent of all suspensions.[51] Moreover, an analysis done by the Department of the Public Advocate showed that in some counties a minority student was at least twice as likely as a white child to be suspended.[52]

There are also deficiencies in educational services for two particularly vulnerable populations of children: the 4,000 emotionally disturbed and mentally retarded children in state facilities and the more than 14,000 New Jersey children who are admitted annually to county facilities such as shelters and detention centers.[53] Both groups of children tend to have acute educational needs and special learning problems, but funding has not been provided to assure adequate educational services for them.

UNEMPLOYED YOUTH

Many New Jersey youth are finding there is no place for them in the job market, and no legitimate way for them to supplement their family's income or support themselves. During the first quarter in 1984, the unemployment rate for youth aged 16-19 was over 20 percent.[54] The picture is even bleaker for minority youth, particularly in the urban areas where the youth unemployment rate ranges as high as 60 percent.[55]

TROUBLED CHILDREN AND FAMILIES

Clearly, many New Jersey families live with the unrelenting stress of being unable to meet their basic survival needs. Further, substantial numbers of families and children are confronting other serious problems which may in part be due to the stress and turmoil associated with deprived life situations.

INCREASING FAMILY VIOLENCE AND CHILD ABUSE

For example, available data points to dramatic increases in the rates of reported family violence and child abuse. Just since 1970, the rates of reported child abuse have risen by 1,000 percent.[56] In 1983 alone, there were 26,398 reports of child abuse and neglect referred to the state's Division of Youth and Family Services, a 28 percent increase over the number of reports in 1982.[57] Preliminary figures for 1984 show that the number of referrals will rise by over 50 percent to 45,000.[58]

CHILDREN IN CRISIS

Parent-child conflicts are bringing more children into the court system, often because parents cannot cope with their children. In 1982, over 11,000 youngsters were brought before the courts on non-criminal complaints for matters such as being runaway, incorrigible and truant.[59] In many instances, these children came from troubled and dysfunctional families, and in some cases the children were found to be the victims of child abuse.

SUBSTANCE ABUSE

The available data indicates that hundreds of thousands of New Jersey's young people abuse drugs and alcohol. To illustrate: The most recent estimates prepared by the Department of Health show that as many as 44 percent of the children between the ages of 12-17 years abuse drugs or alcohol or both substances. In fact, polyabuse is becoming more common and compounding the problems of those young people who do become addicted.[60] Little hard data is available about the association between delinquency and substance abuse. However, according to Department of Corrections (DOC) officials, the majority of the young committed to the state's correctional facilities evidence substance abuse problems and usually they are involved with a combination of drugs and alcohol.[61]

Princeton Packet, Paul Savage, Photographer

Further, hundreds of thousands of New Jersey's children risk harm from parental substance abuse. An estimated 20 to 40 percent of the state's children live with a parent who abuses either drugs or alcohol, and these children are at risk of a host of problems which impair their physical and emotional development.[62] Children in the care of substance abusers show a high incidence of being victims of child abuse, including sexual abuse.[63] Additionally, numerous studies have found a higher rate of adjustment problems among these children as well as higher rates of substance abuse and suicide.[64]

There are pronounced risks as well for children born to women who have abused either alcohol or drugs during pregnancy. Recent, conservative estimates indicate that nearly 600 infants are born in New Jersey each year with a range of physical abnormalities and/or neurological damage resultant from maternal alcohol abuse.[65] Birth defects and handicapping conditions have been reported as well for children whose mothers took drugs while they were pregnant.[66]

EMOTIONALLY DISTURBED CHILDREN

No one knows the full extent of mental illness among New Jersey's children. Data reported by the Department of Education in its 1982-83 annual plan, however, show that nearly 15,000 children receiving special education services have been diagnosed as being emotionally disturbed.[67]

Further, there have been sharp increases in the rate of suicide among New Jersey youths aged 15-24 years. According to the Department of Health, the rate has tripled since 1950, and in 1982 there were 111 suicides out of 10,699 deaths. Suicide now ranks as the second leading cause of death for New Jersey adolescents.[68] And, the true incidence of suicide among this population is probably under-reported, both because of social stigma and because certain traffic fatalities are erroneously not identified as suicides.[69]

While at least 1,000 New Jersey children and youth receive care in residential centers or psychiatric hospitals each year, transitional facilities are not readily available for those youth who cannot adapt to their homes or to independent living situations. Consequently, many of these youth are at risk of joining the ranks of the homeless or requiring long-term institutional care.[70]

Increasing numbers of the youth committed to the Department of Corrections manifest very severe emotional problems. In some instances, these youth have been sent to DOC primarily because there just is no other available program for them. But, DOC does not currently have the capability to provide the specialized services these youth require. (See Specialized Services for Emotionally Disturbed Offenders section of this report for additional details.)

CHILDREN IN CONFLICT WITH THE LAW

Perhaps one of the most significant indicators of the extent of problems among our young people is the delinquency rates. Arrest data for 1982 show 107,320 arrests of young people under the age of 18.[71] Further, in 1982, 91,020 delinquency complaints against children were filed with the courts,[72] and there were 9,736 admissions to juvenile detention centers.[73] Available data also show an increase in the number of commitments of juveniles to the Department of Corrections; between 1981 and 1982 the number increased by 19 percent to 1,136.[74]

There are strong indications that many of the young people coming into the juvenile justice system are there primarily because appropriate preventive and alternative services are not being provided for them. However, these statistics do show that tens of thousands of New Jersey's young people are evidencing pronounced and troubled reactions to parental, educational and community responses to their needs. It is significant to note that the vast majority of the children who ultimately are sent to locked detention centers and correctional facilities are minority children from the state's poorest communities with the least resources for education and community support services.[75]

NOTES

1. R. Alexandra Larson and Carol Kasabach, *Linking Policy with Need* (Trenton, NJ: New Jersey Commission on Children's Services, 1982), pp. 31-35, and U.S. Congress, House, Select Committee on Children, Youth and Families, *Children, Youth and Families: 1983, A Year-End Report*, 98th Cong., 2d sess. (Washington, DC: U.S. Government Printing Office, 1984).
2. U.S. Congress, House, *Children, Youth and Families: 1983, A Year-End Report*, p. viii.
3. *Ibid.* p. vii.
4. Larson and Kasabach, *Linking Policy with Need.*
5. Data provided by the New Jersey Department of Labor as derived from the U.S. Census, 1980. The poverty level set by the federal government for 1984 is an annual income of $10,200 for a family of four; for each additional family member, $1,740 is added.
6. In 1980, the National Social Science and Law Project found that, in New Jersey, an annual income substantially above the federal poverty level ($7,450 in 1980 for a family of four) was required just to provide the basic necessities of life. For example, based upon 1980 costs, a New Jersey family of four would require an annual income of at least $12,192 or 163 percent more than the poverty level to meet minimal survival needs. Available 1980 federal census data provided by the New Jersey Department of Labor indicates that at least 250,000 New Jersey families had incomes below the standard identified by the National Social Science and Law Project. National Social Science and Law Project, *The Cost of An Adequate Living Standard in New Jersey* (Washington, DC: 1980).
7. Based upon estimates derived from the U.S. Census, 1980.
8. For example, the current AFDC monthly benefit level of $443 for a family of four would provide a family with an annual cash income of $5,316 which represents only 44 percent of the minimum cost of living in New Jersey as measured in 1980. When benefits for food stamps are added in, the total annual value of the benefits is $7,056 or 58 percent of the 1980 estimate of the minimum cost of living as reported by the National Social Science and Law Project in *The Cost of An Adequate Living Standard in New Jersey.* If the 1980 estimates of the minimum cost of living in New Jersey were adjusted for inflation since 1980, the deficiencies of the AFDC benefits would be even more pronounced.
9. The $7,056 total annual value of cash and food stamp benefits provided for the AFDC family of four is $3,444 less than the 1984 federal poverty level of $10,200.
10. Shirley Geismar, Tricia Fagan and Patricia Deignan, *Through the Safety Net: A Citizen's Report on N.J. Families and Children* (Newark, NJ: Association for Children of New Jersey, 1983).
11. *Ibid.*, p. 13.
12. Geismar, Fagan and Deignan, *Through the Safety Net;* Isabel Wolock, Ludwig Geismar, Bruce Lagay and Phylis Raiffe, *Final Report—Impact of OBRA Policies on AFDC Families: A Study of Middlesex County Families* (New Brunswick, NJ: Rutgers University Graduate School of Social Work, 1984); and Shirley Geismar, *Not Enough to Live On: A Survey of Living Costs and Conditions of Head Start Families in Newark* (Newark, NJ: Newark Pre-School Council and the Association for Children of New Jersey, 1984).
13. Geismar, Fagan and Deignan, *Through the Safety Net,* p. 15.
14. *Ibid.*
15. *Final Report of the Assembly Housing Emergency Action Team* (HEAT), June, 1981 (chaired by Senator Leanna Brown).
16. George Sternlieb, Robert W. Lake, Richard L. Florida, Robert W. Burchell, W. Patrick Beaton and David Listokin, *Mount Laurel II: Challenge and Delivery of Low-Cost Housing* (Piscataway, NJ: Center for Urban Policy Research, Rutgers University, 1984).
17. Joseph G. Feinberg, (Chief, Bureau of Housing Services, New Jersey Department of Community Affairs), provided this estimate, November 18, 1983.
18. Geismar, Not Enough to Live On, p. i.
19. Geismar, Fagan and Deignan, *Through the Safety Net;* Geismar, *Not Enough to Live On,* and Wolock, Geismar, Lagay and Raiffe, *Final Report—Impact of OBRA Policies on AFDC Families.*
20. Stephen Eisdorfer, Esq., "Housing New Jersey's Children," *Association for Children of New Jersey Newsletter,*

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25. *Ibid.*
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30. Based upon statistics reported by the New Jersey Department of Human Services to the U.S. Department of Health and Human Services for 1983 in "Statistical Report on Medical Care: Recipients, Payments and Services," Health Care Financing Administration Form 2082. This report shows that of the 357,672 Medicaid recipients between the ages of birth to 20 years, 38,954 were screened, January, 1984.
31. The New Jersey Department of Human Services has estimated that there are 100,000 children whose families have incomes below 133 1/3 percent of the Aid to Families with Dependent Children (AFDC) standard of need. The incomes of these families, while too high to qualify them for AFDC, are less than the Federal poverty guideline. The Department's estimate also includes those families whose total medical expenses exceed the amount of that portion of their income which is in excess of 133 1/3 percent of the AFDC standard of need. Thus, even families whose incomes exceed the eligibility criteria are considered medically needy when their medical expenses consume their excess income.
32. Larson and Kasabach, *Linking Policy with Need* and Geismar, Fagan and Deignan, *Through the Safety Net.*
33. New Jersey Department of Education, Division of Special Education, *Population Study for Early Intervention Programs in New Jersey, 1982* (1982).
34. Data provided by the New Jersey Developmental Disabilities Council.
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36. Based upon data reported in *Adolescent Parent Program Proposal* (Trenton, NJ: New Jersey Department of Human Services, Division of Public Welfare, 1983), p. 46.
37. *Ibid.*, p. 47
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49. New Jersey Department of Education, *Vital Educational Statistics* (Trenton, NJ: 1983).
50. See suspension data reported for 1977-78, 1978-79, 1979-80 and 1980-81 in New Jersey Department of Education, *Vital Educational Statistics* (Trenton, NJ: 1979, 1980, 1981, 1982). Statistics for 1981-82 provided by the New Jersey Department of Education, Office of Management Information, September 30, 1983.
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54. Data provided by the New Jersey Department of Labor.
55. Precise data on the unemployment rate among urban minority youth has not been gathered, but trends identified by the New Jersey Department of Labor suggest that the rates may be triple the overall youth unemployment rate.
56. The 1,000 percent increase actually reflects the increased number of reports between 1970 and 1980, New Jersey Department of Human Services, Division of Youth and Family Services, *Grant Application for the Development of the Agency's Capacity to Divert Clients from the Juvenile Justice System* (1980). Since 1980, the numbers of reported cases of child abuse have continued to increase from year to year.
57. New Jersey Department of Human Services, Division of Youth and Family Services, Bureau of Research, Evaluation and Quality Assurance, *Child Abuse and Neglect in New Jersey: Incidence Per County in 1983* (Trenton, NJ: 1984).
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61. Information reported to the Governor's Committee on Children's Services Planning by the New Jersey Department of Corrections, 1984. In a recent, careful review of intake records of juvenile cases in Essex County, it was found that approximately 6,000 of 13,000 recorded cases were diverted to Juvenile Probation Intake in a single year. Of these 6,000 cases, approximately 43 percent had alcohol, drug or poly substance related problems and 35 percent of the 6,000 were basically problem drinkers. Reported by Carol Perna, (Assignment Clerk, Superior Court of New Jersey, Chancery Division, Family Part, County of Essex) in a Memorandum to Linda Knowlton, (Project Developer of The Shire, Mendham, New Jersey), July 13, 1984.

62. Estimates of the number of children living with parents who abuse substances range from a "low" of 20 percent in homes where the parent is abusing alcohol as reported by Janet Woititz, Ed.D., author of *Adult Children of Alcoholics* (Hollywood, FL: Health Communications, Inc., 1983), letter, March 8, 1984, to a "high" of 1,400,000 children in New Jersey living with a parent who abuses alcohol as reported in *State Plan Profiles* (Rockville, MD: State Assistance Branch, Alcohol, Drug Abuse, and Mental Health Administration, 1978). In addition, the Gallup Organization reported that 40 percent of young people (between the ages of 18 and 24) surveyed stated that drinking was a cause of problems in the family, The Gallup Organization, *Alcohol Abuse in America* (Princeton, NJ: November, 1982).

63. *1980 New Jersey Combined Alcohol and Drug Abuse Prevention and Treatment Plan* (Trenton, NJ: New Jersey State Department of Health, 1979).

64. Roy W. Pickens, Ph.D. *Children of Alcoholics* (Center City, MN: Hazelden, 1984).

65. Carol Kaslander, New Jersey Department of Health, Division of Alcoholism, (F.A.S. Project Coordinator), "Fetal Alcohol Syndrome—Recommendations for Implementation," Memorandum, March 26, 1984.

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67. New Jersey Department of Education 1982-83, *Annual Plan for the Education of All Handicapped Children* (Trenton, NJ: 1981).

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72. Statistics reported by the New Jersey Administrative Office of the Courts, May, 1984 and based upon the "Monthly Reports of the Clerks of the Juvenile and Domestic Relations Courts to the Administrative Office of the Courts, September, 1982—August, 1983."

73. New Jersey Department of Corrections, Juvenile Detention and Monitoring Unit, *Statistics on Juveniles in Detention Facilities* (1982).

74. New Jersey Department of Corrections, Division of Juvenile Services, Application to the State Law Enforcement Planning Agency for funding to establish a Youth Advocacy Project (dated 1983).

75. Stephen Eisdorfer, (Assistant Deputy Public Advocate, New Jersey Department of the Public Advocate), testimony before the New Jersey Commission on Children's Services, September 21, 1981; Larson and Kasabach, *Linking Policy with Need;* Linda J. Wood and Joan Hammond Brame, *Children in Detention and Shelter Care: Surveying the System in New Jersey* (Newark, NJ: Association for Children of New Jersey, 1979); and Linda J. Wood and Carl Moore, *Beneath the Labels: Children in Detention and Shelter Care* (Newark, NJ: Association for Children of New Jersey, 1981).

III.

- IMPOVERISHED CHILDREN AND FAMILIES: MEETING THE NEED FOR ADEQUATE INCOME SUPPORTS THROUGH AFDC
- HOUSING NEW JERSEY'S CHILDREN AND FAMILIES
- PREVENTIVE AND REMEDIAL HEALTH CARE SERVICES FOR CHILDREN
- MEETING EDUCATIONAL NEEDS

Princeton Packet

ACTIONS TO ASSURE BASIC FOUNDATIONS FOR LIFE

INTRODUCTION

Children are dependent upon adults to meet their survival needs and to assure that the basic foundations of life are consistently provided to nurture their development. Those basic foundations for life include: nutritionally adequate food, safe and decent shelter, health care and sufficient education to develop basic skills for life and self-support.

In New Jersey, many children are growing up without these basic foundations for life because their families do not have sufficient income to meet their basic needs and government has not made adequate provisions to assure the well-being of these children. Further, many children are not receiving adequate educational services to prepare them for adulthood.

This Chapter reports the Governor's Committee's recommendations for specific actions to:

- Provide adequate income supports for impoverished families so that the basic survival needs of children can be met
- Provide safe, decent and affordable housing for children and families
- Provide preventive and remedial health care services for children
- Eliminate deficiencies in the educational system

IMPOVERISHED CHILDREN AND FAMILIES: MEETING THE NEED FOR ADEQUATE INCOME SUPPORTS THROUGH AFDC

Many families, through no fault of their own, do not have sufficient income to meet their basic survival needs. While job training and placement services can help a substantial number of these families to increase their income, most need at least temporary assistance to meet the essential needs of the family members.

- MORE THAN 270,000 CHILDREN AFFECTED IN NEW JERSEY
- BENEFITS TO AFDC FAMILIES COVER LESS THAN 60 PERCENT OF MINIMUM COST OF LIVING IN NEW JERSEY
- INFLATION HAS RISEN BY 80 PERCENT BUT AFDC BENEFITS HAVE BEEN INCREASED BY ONLY 33 PERCENT
- THE REAL VALUE OF AFDC BENEFITS HAS BEEN SUBSTANTIALLY ERODED
- RATHER THAN PREVENTING HOMELESSNESS, AFDC BENEFIT LEVELS HELP CAUSE IT
- REDUCED BENEFIT LEVELS FOR N SEGMENT FAMILIES PENALIZE CHILDREN
- DIFFERENTIAL BENEFIT LEVELS FOSTER FAMILY BREAK-UP

New Jersey Department of Human Services

In New Jersey, the Aid to Families with Dependent Children (AFDC) is the single most important income support program available for impoverished children and families. However, over the years benefit levels have not been regularly adjusted to compensate for inflation and, despite the fact that a 7 percent increase was provided for 1984, the AFDC benefits are not adequate to meet the basic survival needs of the hundreds of thousands of children who must rely upon them.

Funded jointly by federal, state and county funds, the AFDC program provides cash assistance in the form of monthly grants to families with children. The program, which is supplemented by food stamps and Medicaid coverage for health care services, has three different segments:

- C Segment—provides assistance to children who are deprived of the support of at least one parent due to death, absence or incapacity.
- F Segment—provides assistance to children when both parents are in the home but do not have enough income to adequately support the children due to underemployment as defined by federal regulations.
- N Segment—also provides assistance to families when both parents are in the home. However, N segment families differ from F segment families in that the parents do not meet the federal definition of unemployed or underemployed because they have been found to have had no significant attachment to the labor market. Federal funds are not provided for N segment families, and the **benefit levels are 33 percent less than for the C and F segments.**

The monthly AFDC benefit for the C and F segments for a family of four totals $443. N segment families receive $295 a month.[1]

MORE THAN 270,000 CHILDREN AFFECTED IN NEW JERSEY

More than 270,000 or 12 percent of New Jersey's children rely upon AFDC to meet their basic survival needs, and about 6,000 children receive only the lower-level N segment benefit. Statewide, about 135,000 families are enrolled in the AFDC program.[2]

HARM TO CHILDREN

The inadequacy of current AFDC benefit levels is having severe consequences for the children who rely upon the benefits for their survival. Families are being forced to make rather drastic choices among basic necessities, and many children are growing up without proper nutrition and often in unsafe housing situations.

As documented in the Association for Children of New Jersey's (ACNJ) Child Watch Report, **Through the Safety Net** (1983), growing numbers of families are turning in desperation to emergency food centers which no longer can meet their needs. The plight of AFDC families has been exacerbated by cuts in other services and there is a new phenomenon of children who are growing up "chronically hungry."[3]

Further, the caseload composition of the Division of Youth and Family Services (DYFS) shows that thousands of AFDC families are experiencing crises which require the costly intervention of social service agencies. According to ACNJ's study, social service providers report a "growing sense of desperation and defeatist attitudes among children and families they assist" as well as a "noticeable increase in family disintegration."[4] Research conducted by DYFS and Rutgers University strongly suggests that these poverty-related stresses expose children to an increased risk of abuse and neglect.[5]

BENEFITS TO AFDC FAMILIES COVER LESS THAN 60 PERCENT OF THE MINIMUM COST OF LIVING IN NEW JERSEY AND ARE FAR BELOW THE FEDERAL POVERTY GUIDELINE

The National Social Science and Law Project, using "an unmistakably conservative estimate of a minimally adequate standard of living" required in **The Cost of an Adequate Living Standard in New Jersey** that $12,192 annually would be required to provide a family of four with the basic necessities of life in 1980.[6] However, even when food stamp benefits are added, the total annual benefits available to the AFDC family of four today are only $7,056—not even 60 percent of the minimum cost of living in New Jersey as measured in 1980. This is the total annual benefit package for the AFDC C and F segments. The N segment families receive only $5,280 annually—less than 45 percent of the minimum cost of living.

According to the National Project, the cost of housing alone for a New Jersey family of four was $4,505 annually in 1980[7]—nearly as much as the $5,316 annual AFDC cash benefit for the C and F segments. The total combined cost for **just** food and housing in New Jersey for a family of four annually is $9,144—well beyond the purchase power of the AFDC family.[8]

Thus, an AFDC family in New Jersey does not have sufficient income to even meet basic food and housing needs, let alone cover other necessities such as clothing and transportation.

Further, as illustrated in Graph 3.1, New Jersey's AFDC benefits also fall far short of the 1984 Federal Poverty Guideline of $10,200 for a family of four.

INFLATION HAS RISEN BY 80 PERCENT BUT AFDC BENEFITS HAVE BEEN INCREASED BY ONLY 33 PERCENT

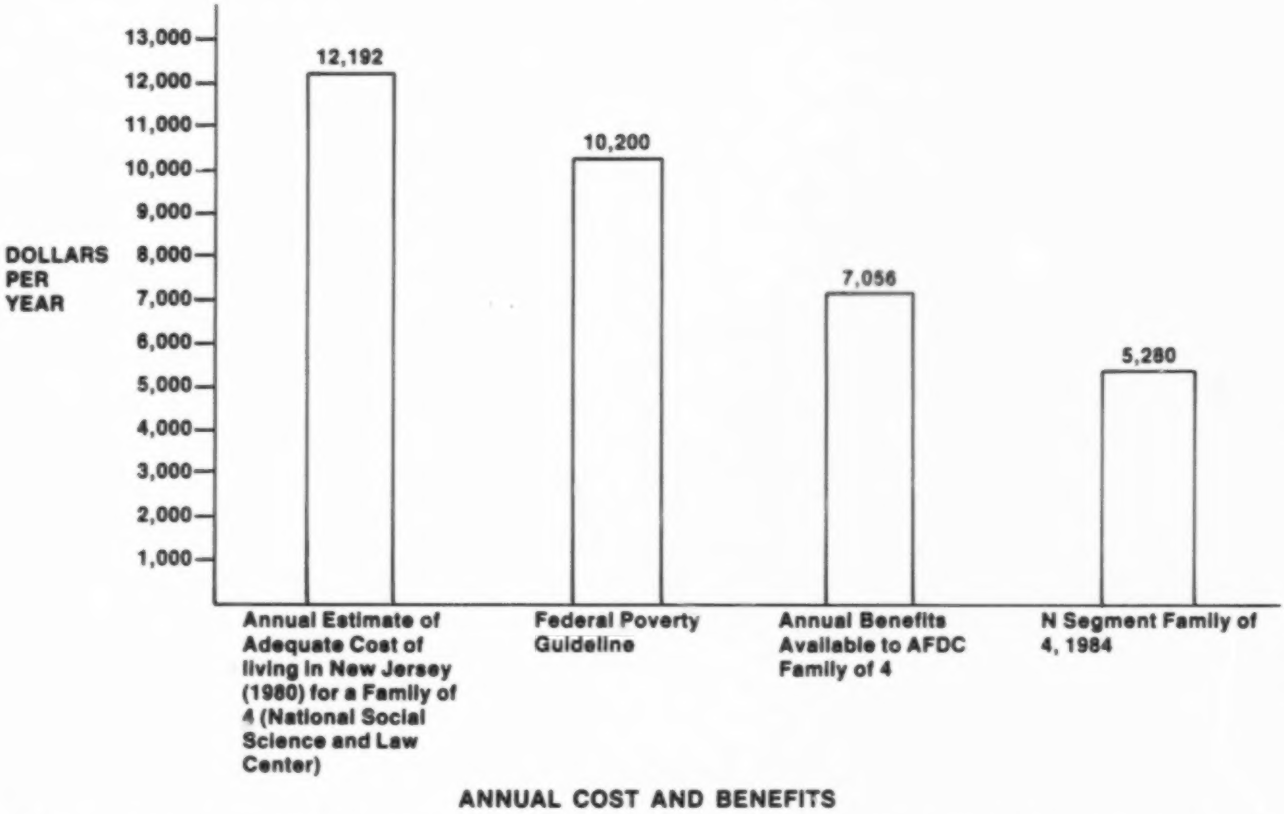
In contrast to other income programs such as Supplemental Security Income (for the aged and disabled), AFDC benefits are not adjusted annually for inflation. Since 1971, the overall rate of inflation has risen about 80 percent with costs for energy and housing increasing 116 percent and 66 percent, respectively.[9] During the same period, AFDC benefits have been increased by only 33 percent.

THE REAL VALUE OF AFDC BENEFITS HAS BEEN SUBSTANTIALLY ERODED

In the wake of soaring inflation, the real value of

Graph 3.1

COST OF LIVING PER YEAR IN NEW JERSEY
AS COMPARED TO ANNUAL AFDC BENEFITS



From: New Jersey Department of Human Services, Division of Public Welfare, "Comparison of BLS Lower Income Budget, Family Consumption Items Compared with AFDC Standards (Plus Food Stamp Benefits), Fiscal Years 1972-82" (This unpublished table also includes comparative data for 1983 and 1984). National Social Science and Law Center, *The Cost of an Adequate Living Standard in New Jersey* (Washington, DC: 1980).

AFDC benefits has been substantially eroded. As a result, the capacity of AFDC families to maintain a decent standard of living has steadily decreased.

For example, in 1972 the monthly AFDC benefit coupled with food stamps for a family of four represented 76 percent of the Bureau of Labor Statistics (BLS) Lower Income Monthly Budget.[10] Today, the AFDC family's combined benefit package represents only 59 percent of the BLS Budget.[11] Further, based on BLS statistics, the AFDC family's purchasing power will continue to shrink if the benefit level is not increased. According to the BLS, shelter (rental) costs have doubled since 1981, increasing from $102 a month to $216 for a family of four.[12] At the same time, as illustrated in Graph 3.2, monthly food costs have soared from $153 to $387 for a family of this size.[13]

RATHER THAN PREVENTING HOMELESSNESS, AFDC BENEFIT LEVELS HELP CAUSE IT

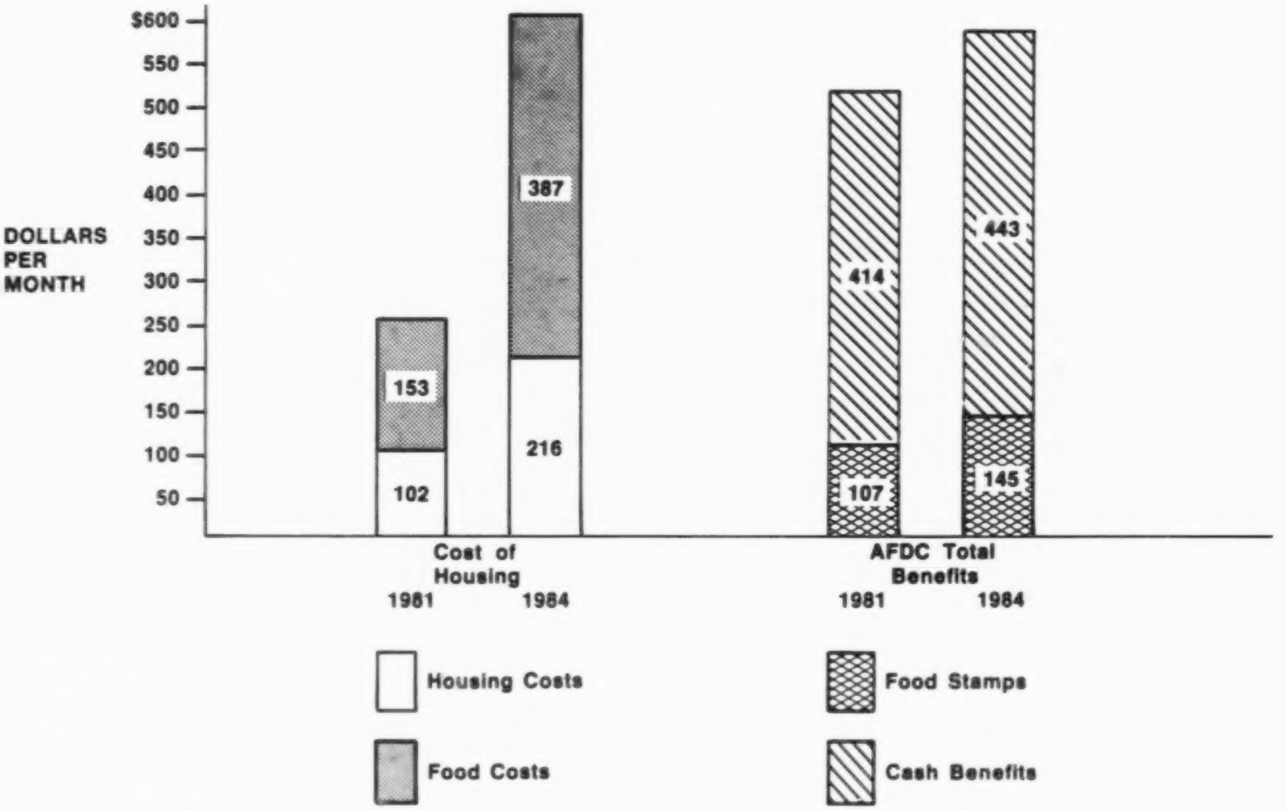
According to the **1983 Report of the Governor's Task Force on the Homeless** benefit levels help to actually cause homelessness "since clients in many instances are forced into choosing between paying for shelter and/or utilities or other necessities of life such as food and clothing.[14] And, a 1983 DYFS **Foster Care Utilization** study shows that lack of housing is **the second major cause** of family disruption resulting in foster home placement of the children.[15]

REDUCED BENEFITS FOR N SEGMENT FAMILIES PENALIZE CHILDREN

Children in two-parent families have needs as urgent as those of children in single-parent families. Yet, the benefits currently provided for children in the two-parent N segment families are one-third less than those provided for other children enrolled in AFDC. In fact, the monthly benefit of $295 for a family of four, even when combined with the value of the food stamps provided, represents less than 52 percent of the federal poverty guidelines for a family of that size and less than 45 percent of the minimum cost of living in New Jersey.[16]

Graph 3.2

COST OF LIVING IN NEW JERSEY AS COMPARED WITH AID TO FAMILIES WITH DEPENDENT CHILDREN, 1981 AND 1984



From: New Jersey Department of Human Services, Division of Public Welfare, "Comparison of BLS Lower Income Budget, Family Consumption Items Compared with AFDC Standards (Plus Food Stamp Benefits), Fiscal Years 1972-82" (This unpublished table also includes comparative data for 1983 and 1984) and "Comparison of BLS Lower Income Budget by Component."

Thus, although the federal regulations which deny matching funds for benefits to these families are designed to prompt employable adults back into the labor force, their most significant impact is to penalize children whose survival needs cannot possibly be met on this reduced benefit level. In addition to being deprived of adequate food, clothing and shelter, many of these children are subjected to **magnified poverty stresses** which set a climate for child abuse and serious family disruption.

DIFFERENTIAL BENEFIT LEVELS FOSTER FAMILY BREAK-UP

Perhaps most importantly, the benefit schedule actually encourages family break-up because the family can receive a higher benefit level when one of the "employable" parents leaves the home. This pattern has been widely noted by the county welfare departments who have reported that many families enrolled in the AFDC N segment suddenly transfer to the C segment because one parent has left the family unit.[17]

For many children, the difference in the benefit levels makes the difference as to whether both of their parents remain involved with their care. Equalizing the AFDC N segment benefit level with that for the other AFDC segments would increase the likelihood that vulnerable, struggling families will stay together.

The estimated annual cost to the state of equalizing the benefits for a projected total of 2,600 families would be $3.6 million.[18] Today, when rates of family break-up are steadily increasing in New Jersey and the numbers of single-parent families continue to rise, there is a pronounced need for public policies, especially those concerning income support programs, to encourage family unity.

RECOMMENDED ACTIONS

I. ASSURE THAT AFDC CHILDREN WILL BE SUPPORTED AT LEAST AT THE POVERTY LEVEL

The state should provide for increases in the AFDC grant level with a goal of assuring that children who require AFDC will be supported at least at the poverty level. While it may not be possible to achieve this goal in one step, the amount of the increase in this year's budget should be maximized. Further, the process of raising the grant to an adequate level should be continued from one year to the next.

II. ESTABLISH PROVISION FOR AUTOMATIC INCREASES TO COMPENSATE FOR INFLATION

The state should establish a mechanism to assure that the AFDC grant level is automatically increased to compensate for the rate of inflation in any given year.

III. EQUALIZE BENEFIT LEVELS FOR N SEGMENT FAMILIES—FOSTER FAMILY UNITY

To foster family unity and to remove the current financial incentive for one parent to leave the home, the benefit levels for AFDC N segment families should be increased to equalize them with the benefit levels for the C and F segment families. Benefits for the N segment should be based upon the same needs assessments and assistance standards used for the C and F segments.

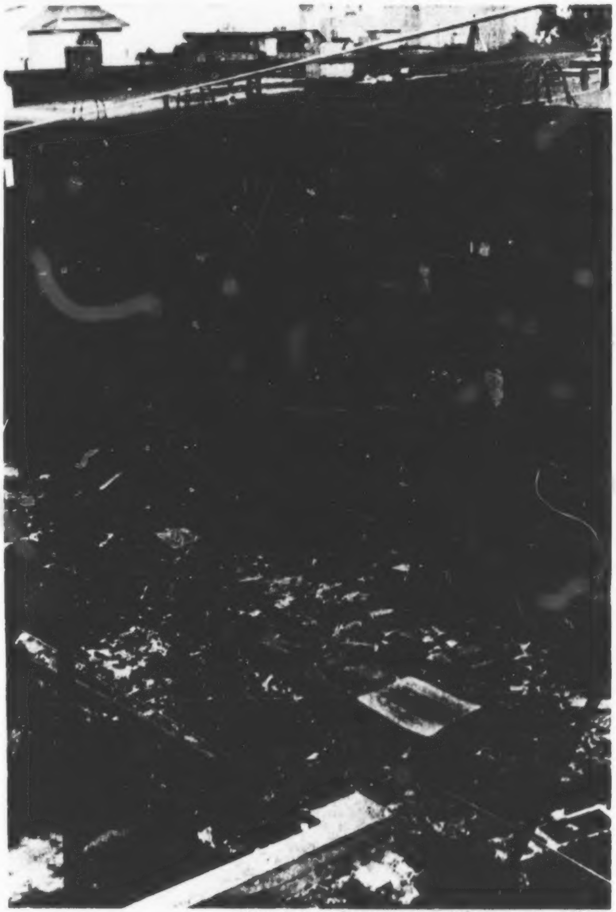
NOTES

1. New Jersey Department of Human Services, Division of Public Welfare, *Assistance Standards Handbook*, General Provisions 10:82-1.2, (c) Public Assistance Allowance Standards AFDC Program, Transmittal Letter No. 40 (Trenton, NJ: July 1, 1984).
2. Information provided by the New Jersey Department of Human Services, Division of Public Welfare from 1984 caseload statistics.
3. Shirley Geismar, Tricia Fagan and Patricia Deignan, *Through the Safety Net: A Citizen's Report on New Jersey Children in Need* (Newark, NJ: Association for Children of New Jersey, 1983), pp. 13-15.
4. *Ibid.*, p. 15.
5. Leroy H. Pelton, *Child Abuse and Neglect and Protective Intervention in Mercer County, New Jersey: A Parent Interview and Case Record Study* (Trenton, NJ: New Jersey Department of Human Services, Division of Youth and Family Services, 1977); Isabel Wolock and Bernard Horowitz, *Factors Relating to Levels of Child Care Among Families Receiving Public Assistance in New Jersey* (Trenton, NJ: New Jersey Department of Human Services, Division of Youth and Family Services, 1977); Robert Arden and Bernard Horowitz, *Relationship Between Socioeconomic Characteristics of New Jersey Counties and DYFS Utilization Rate* (Trenton, NJ: New Jersey Department of Human Services, Division of Youth and Family Services, undated); Isabel Wolock and Bernard Horowitz, "Child Maltreatment and Material Deprivation Among AFDC-Recipient Families," *Social Service Review*, Vol. 53 (June, 1979) pp. 175-194; and Isabel Wolock and Bernard Horowitz "Child Maltreatment as a Social Problem: the Neglect of Neglect," *American Journal of Orthopsychiatry*, Vol. 54, No. 4 (October, 1984) pp. 530-543.
6. National Social Science and Law Center, *The Cost of An Adequate Living Standard in New Jersey* (Washington, DC: 1980).
7. *Ibid.*, p. C-3.
8. *Ibid.*, p. 19. Food and housing rate costs are estimated to constitute about 75 percent of the total budget required for a minimally adequate standard of living in New Jersey. The figure $9,144 represents 75 percent of the full $12,192 budget and Minimum Adequacy Budget Component Costs For Different Households: Statewide Averages, Table 2, pg. 15.
9. Data on the rate of inflation reported by the Association for Children of New Jersey, "Facts About the AFDC Program" (fact sheet released in 1984).
10. New Jersey Department of Human Services, Division of Public Welfare, "Comparison of BLS Lower Income Budget, Family Consumption Items with AFDC Standards (Plus Food Stamp Benefits), Fiscal Years 1972-82" (This unpublished table also includes comparative data for 1983 and 1984).
11. *Ibid.*
12. Percentages based upon data reported by the New Jersey Department of Human Services, Division of Public Welfare, "Comparison of BLS Lower Income Budget by Component" (unpublished table).
13. *Ibid.*
14. *Report of the Governor's Task Force on the Homeless* (Trenton, NJ: New Jersey Department of Human Services, 1983), p. 14.
15. Carol Williams, Barbara Catterall and Leonard Feldman, *Foster Care Utilization—Metro Region* (Trenton, NJ: New Jersey Department of Human Services, Division of Youth and Family Services, Bureau of Research, Evaluation and Quality Assurance, 1983).
16. This percentage is based upon a comparison with the minimally adequate budget for 1980 as estimated by the National Social Science and Law Center, *The Cost of An Adequate Living Standard in New Jersey*.
17. The full extent of this pattern has not been formally documented. However, it has also been reported that, in many instances, one parent leaves the home at the time of the intital AFDC application so that the family will qualify right from the start for the higher benefit level.
18. Estimate provided by the New Jersey Department of Human Services, Division of Public Welfare, April, 1984.

HOUSING NEW JERSEY'S CHILDREN AND FAMILIES

The shortage of safe, decent, affordable housing for families with children is one of the most critical issues confronting New Jersey. Many children live in unsafe housing conditions, and many are deprived of basic necessities because their families must spend a disproportionate amount of their income on housing.

- ONE MILLION NEW JERSEYANS LIVE IN SUBSTANDARD HOUSING
- ACUTE SHORTAGE OF SAFE, AFFORDABLE HOUSING
- DOWNWARD TREND IN HOUSING GROWTH
- MANY FAMILIES ARE PRICED OUT OF THE HOUSING MARKET
- IMPACT MOST ACUTE FOR THE POOR AND URBAN RESIDENTS
- UNSAFE HOUSING CONDITIONS THREATEN CHILDREN
- FAMILIES SPEND A DISPROPORTIONATE PERCENTAGE OF THEIR INCOME FOR HOUSING
- "HOUSE POOR" FAMILIES CANNOT MEET CHILDREN'S MEDICAL AND NUTRITIONAL NEEDS
- RENTAL DISCRIMINATION
- INCREASING NUMBERS OF HOMELESS
- SHARP DECLINE IN FEDERAL SUPPORT FOR HOUSING
- LOCAL REGULATORY PRACTICES IMPEDE DEVELOPMENT
- NEW JERSEY HOUSING INITIATIVES



New Jersey Department of Community Affairs

A place to live—a shelter—has always been one of the basic human survival needs. In our modern society, safe and sanitary housing is viewed as a necessity for human health and dignity.

ONE MILLION NEW JERSEYANS LIVE IN SUBSTANDARD HOUSING

Yet in New Jersey today an estimated 12.2 percent or 285,395 of the state's 2.3 million housing units are dilapidated or deteriorating. About one million New Jersey residents, nearly 14 percent of the state's population, live in substandard housing, according to the Department of Community Affairs,[1] often with structural deficiencies that expose the inhabitants to health hazards and risk of injury. Many of these "inhabitants" are children, and many are very young children who are especially vulnerable to health problems and injuries resulting from unsafe and unsanitary housing conditions.

ACUTE SHORTAGE OF SAFE, AFFORDABLE HOUSING

And, statewide there is an acute shortage of safe, affordable housing for families from all but the highest income brackets. According to a special report prepared by the **New Jersey Assembly Housing Emergency Action Team (HEAT),** new housing starts simply have not kept pace with the demand.[2]

DOWNWARD TREND IN HOUSING GROWTH

For example, in 1971 the Deparment of Community Affairs (DCA) estimated that at least 80,000 new units would have to be built annually to meet the demand over the 1970s. But, the number of housing starts for the decade averaged only about half of the estimated need.[3] Further, during the past decade, the rate of construction of new rental units in New Jersey sharply decreased, dropping from 30,000 per year to an all time low of less than 5,000.[4]

During the next decade, a total of 750,000 new housing units is needed just to replace substandard housing and accommodate growth.[5] Currently, at least 120,160 units are needed for modest-income families living in deficient housing, and an additional 123,933 units will be needed during the next 15 years. But, the downward trend in the overall growth rate of the net housing supply is expected to continue through the next two decades.[6]

MANY FAMILIES PRICED OUT OF THE HOUSING MARKET

Further, increasing numbers of families are finding themselves priced out of the housing market. For example, HEAT found that the estimated cost of the average newly constructed home in New Jersey is more than $80,000.[7] But the average family income in New Jersey is only $24,000,[8] sufficient to support a mortgage of no more than $36,000.[9]

In fact, only families with annual incomes over $53,000 would be able to afford the average newly constructed New Jersey home.[10] Thus, even middle-income families and successful young professionals would find a new home out of their financial reach.

IMPACT MOST ACUTE FOR THE POOR AND URBAN RESIDENTS

The situation is particularly bleak for the more than 220,000[11] low-income families who will require housing over the next 15 years, especially those families living in urban areas where most of the poor are clustered. As our Supreme Court recognized in the **Mount Laurel II** decision, there is an enormous problem of inadequately housed, poor living in "urban slums."[12]

To compound the situation, low-income housing construction in the major urban areas continues to fall far short of the need. Simultaneously, the existing low-income housing stock, particularly public housing, is rapidly deteriorating, and many families are forced to live in deplorable conditions. In fact, following a tour of public housing in Newark, a federal Department of Housing and Urban Development (HUD) official commented that neither human beings nor animals should have to live under such conditions.[13]

UNSAFE HOUSING CONDITIONS THREATEN CHILDREN

Further, as documented by a recent study of 551 low-income families of children enrolled in the Head Start program in Newark, the squalid conditions are not confined to public housing. This 1984 study found that 61 percent of the families had rats in their apartments, 90 percent had roaches, and nearly 50 percent had other housing deficiencies such as peeling paint and leaking ceilings. The study concluded that "Although public health professionals have long seen the connection between rat and roach infestation and flaking paint on the one hand, and disease and lead poisoning on the other, extremely large numbers of Newark children live in neighborhoods and housing units where these conditions are commonplace and unaddressed."[14]

FAMILIES SPEND A DISPROPORTIONATE PERCENTAGE OF THEIR INCOME FOR HOUSING

These low-income families face painful choices: to either reside in deficient housing, thereby risking serious harm to their children or spend a disproportionate amount of their income on better housing, thereby leaving themselves unable to purchase other necessities such as food and health care for their children. Currently, three out of four—76 percent—of the 394,000 lower-income households in New Jersey who are renters are paying more than they can afford for shelter. Similarly, 200,000 or 69 percent of the lower-income families who own homes are paying more than they can afford for housing, using more than 25 percent of their gross income for shelter.[15]

"HOUSE POOR" FAMILIES CANNOT MEET CHILDREN'S MEDICAL AND NUTRITIONAL NEEDS

That many families are simply unable to play the budget-juggling game without shortchanging their children has been documented in several recent New Jersey studies which show that a substantial proportion of low-income families are unable to pay for medical care for their children or provide minimally nutritious diets. Often other pressing human needs must go unmet in order to make the rent payment or the mortgage.[16]

RENTAL DISCRIMINATION

In New Jersey, many families face the additional problem of rental discrimination which can take these forms: Families with children are denied admission to rental housing: families are evicted following the birth of a child or a change in management policy about the number of children permitted in a rental unit; children of certain ages may be excluded; families are assessed higher rents to cover the damage children are assumed to inflict on dwellings; or single parent families are refused admission. While comprehensive data on practices in New Jersey are not available, a 1980 HUD survey found that half of all renters with children had experienced discrimination in their search for housing,[17] and surveys of New Jersey classified advertising of rental housing in daily newspapers suggest that discrimination is pervasive here.[18]

New Jersey law does prohibit rental discrimination.[19] However, enforcement of the law is spotty; and the penalties, which authorize fines up to $500, are too slight to deter violations.[20] Further, the current statute does not prohibit discrimination on the basis of marital status, parental status, or legitimate source of income. Nor does it prohibit newspapers from publishing advertisements that offer units in discriminatory terms.

INCREASING NUMBERS OF HOMELESS

Perhaps the most serious effect of the housing crisis is the increase in the numbers of homeless families and individuals, an urgent problem addressed by the Governor's Task Force on the Homeless.[21] In fact, lack of housing has been identified as a major cause of family break-up resulting in the need for foster home placement of children.[22]

New Jersey's shortage of safe, decent affordable housing is not a new problem. In fact, as early as 1970, Governor Cahill advised the Legislature in a special report that the state did not have sufficient housing to meet the existing needs of New Jersey's residents, much less the additional needs created by future population and demographic changes.[23]

During the past decade, the severity of the housing shortage has increased. This has been in part due to the national economy. Increased energy costs, construction material costs, and interest rates have all driven up the cost of new housing.

SHARP DECLINE IN FEDERAL SUPPORT FOR HOUSING

The situation has been further exacerbated by a sharp decline in Federal support for housing programs. Total budget authority available through HUD for new activity in assisted housing has decreased by 60 percent since 1981, dropping from $30.9 billion in 1981 to $12.4 billion in 1984.[24] And, while in 1979 the Federal government assisted in the development of 190,000 new housing units nationwide for lower-income families, in 1983 it planned to subsidize only 10,000 new units, virtually all limited to senior citizens.[25] Further, recent cutbacks in Federal funds for rehabilitation have impeded New Jersey efforts to restore deteriorated housing.[26]

The full extent of the HUD funding cuts in New Jersey is not known. However, projections prepared by DCA for a small number of specific programs indicate that **New Jersey will lose over $30 million in funds in 1985 alone.**[27]

Additionally, the Federal government is moving towards reduced support for rental assistance for low-income housing. Proposed measures have included: inclusion of the value of food stamps in determining rents and eligibility for Federal housing programs, thereby increasing a family's rent by 27 percent of the value of food stamps; eliminating current income deductions and exclusions for essentials such as day care and medical costs in calculating rents, thereby raising the rents of tenants who receive Federal subsidies; and reducing the rent subsidy to Section 8 tenants by lowering the basis for estimating fair market rents.[28]

LOCAL REGULATORY PRACTICES IMPEDE HOUSING DEVELOPMENT

Finally, one of the major barriers to the development of affordable housing in New Jersey is local regulatory practices which severely limit the types of housing most likely to be affordable by modest income families, such as garden apartments and mobile homes. Many municipalities have also adopted regulations which drive up the prices of new homes by requiring large lots, large houses and unnecessary amenities. Only a few New Jersey towns have adopted any of the demonstrated effective land-use strategies to draw public and private funds to create affordable housing.[29]

MOUNT LAUREL II: STRONG LEADERSHIP AND TECHNICAL ASSISTANCE NEEDED

These local policies have been declared unconstitutional by the New Jersey Supreme Court in its **Mount Laurel II** decision which requires that municipalities provide realistic housing opportunities for modest-income households.[30] But, strong leadership and technical assistance from state government will be necessary to assist local communities in planning cooperative solutions to meet their obligation to expand housing opportunities.

New Jersey Department of Community Affairs

NEW JERSEY HOUSING INITIATIVES

Over the years, New Jersey has made numerous concerted efforts to spur the development of adequate housing and to take advantage of Federal support for housing initiatives. Housing and building codes have been implemented to ensure that housing is properly constructed and maintained, and special programs such as these have been developed:

- Relocation Assistance
- Rooming and Boarding House Programs
- Senior Citizen Housing
- Projects to remove lead-based paint from houses
- Mortgage Finance Agency (MFA) providing low-interest rate mortgages for first time home-buyers of single units through sale of tax-free bonds, and developing a variety of housing rehabilitation programs
- Housing Finance Agency (HFA) providing modest-income housing units through support of new construction and rehabilitation of existing units[31]

These initiatives have largely been undertaken through the Department of Community Affairs, which served as the base agency for the HFA and the MFA. However, although DCA has steered many innovative housing efforts, it is only one of a myriad of agencies responsible for addressing issues.

COORDINATED EFFORT REQUIRED

In fact, HEAT found that housing production, financing and sales are regulated by at least five administrative departments.[32] At the county level, there are additional bodies such as Housing and Community Development Departments. And, on the municipal level Planning Boards as well as regulatory agencies such as Housing Authorities and Housing Inspection units address housing issues.

Further, numerous public and private social service agencies operate special projects to assist families in finding suitable housing. Additionally, there are a host of business and banking institutions and associations that play a significant role on housing issues.

LACK OF COMPREHENSIVE STATE HOUSING POLICY LEADS TO PIECEMEAL APPROACH

But, there is no comprehensive, consistent State housing policy to provide a framework of housing-related activities. Indeed, HEAT found that attempts to address New Jersey's housing problems have been for the most part "piecemeal, uncoordinated, and, in some cases, detrimental."[33]

The result, according to HEAT, has been the adoption of "programs and policies that are completely counter to the production of an adequate supply of decent, affordable housing." Consequently, there is a "morass of conflicting housing policies and a regulatory nightmare for home-buyers, builders and sellers."[34]

And, in the absence of a comprehensive policy, priority has not always been placed on meeting the most pressing needs. For example, while the MFA was highly successful in using rehabilitation projects to preserve neighborhoods on the verge of becoming blighted, the MFA mortgage funds were not specifically targeted to modest-income groups. Instead, the mortgage funds were spread across income groups without regard to need. Thus, the MFA did not fulfill its potential to significantly expand homeownership opportunities for modest-income families.

NEW INITIATIVES TO BUILD UPON

Over the past year, substantial new initiatives have been mounted to address New Jersey's housing crisis. For example, emergency shelters and a rental assistance program are being developed for the homeless, and legislation has been enacted to facilitate increased use of manufactured housing and mobile homes which are less costly. Further, through legislation, the MFA and HFA have been merged and given broader powers to stimulate housing development. This new entity, the Housing and Mortgage Finance Agency, has also been given a stronger mandate to coordinate state and Federal housing programs.[35]

However, as HEAT found, much remains to be done to eliminate regulatory practices which impede housing development, more efficiently utilize available resources for housing, and develop innovative projects to meet the need for additional housing units.[36] And, these efforts cannot take place in a vacuum. The cooperation and support of the private sector as well as local officials and community groups in identifying, financing and implementing innovative projects are critical ingredients to any plan to alleviate New Jersey's housing crisis.

RECOMMENDED ACTIONS

I. POLICIES AND PROGRAMS TO PROVIDE SAFE, DECENT AND AFFORDABLE HOUSING

Safe, decent and affordable housing must be available to all children and their families. In furtherance of this goal, the state should place a high priority on:

A. HOUSING DEVELOPMENT

The development of appropriate housing in all areas of the state in conformity with the decision of the N.J. Supreme Court in Mount Laurel I and II, taking account of the need for access to employment opportunities, education, social services, transportation and the like. Home ownership should be encouraged, where possible, as pride of ownership is a strong encouragement to maintain housing stock. Further, emphasis should be placed on the development of additional public housing programs and the provision of increased technical assistance to enable municipal governments to meet their "modest income housing" needs. Additionally, the state efforts to provide financial and technical assistance to community groups, builders and developers should be expanded.

B. ALLOCATION OF MFA MORTGAGE FUNDING FOR MODEST-INCOME FAMILIES

The allocation of a specific proportion of Mortgage Finance Agency mortgage monies to modest-income families on an annual basis.

C. URBAN HOUSING—REHABILITATION AND HOMESTEADING

The development of a suitable stock of urban housing. This would include expansion of urban homesteading and rehabilitation of older housing to bring the quality of urban housing to an acceptable level.

D. DEVELOPING SUITABLE RENTAL HOUSING

The enactment of laws protecting and encouraging the development of suitable rental housing for families with income below 80 percent of the average income for their counties. The rates of conversion of rental housing to condominiums should be closely monitored to assure that such conversions do not result in seriously reducing the stock of rental housing for modest-income families.

E. RENTAL ASSISTANCE PROGRAM

The development of a rental assistance program for families whose income is below 80 percent of the county median. Such a measure, which we understand has been under consideration, would complement the Federal Section 8 Rental Assistance Program which, while extensively utilized in New Jersey, has not come close to meeting the state's need.

F. UTILIZATION OF MODULAR HOUSING

Encouraging the production and utilization of modular housing (industrially produced) since it is (exclusive of land costs) 20 percent cheaper than conventionally built housing.

II. OVERSIGHT AND COORDINATION OF HOUSING-RELATED PROGRAMS

A single entity should be given responsibility for coordination of all housing-related programs in state government. This entity should have access to the traditional housing office within the Department of Community Affairs (DCA) and the ability to work closely with other state departments such as Banking, Insurance, Environmental Protection, Law and Public Safety, and Commerce and Economic Development as well as Federal, County and local government agencies to assure that policies affecting housing are coordinated and that new programs are developed. This body should also develop new legislative initiatives needed to expand the state's housing stock.

III. ESTABLISH SPECIAL GOVERNOR'S TASK FORCE

A special Governor's Task Force should be established to act, in conjunction with the Assembly Committee on Housing and Urban Policy, in an advisory capacity to the entity charged with overall responsibility for coordination of statewide housing efforts. This Task Force should include key business leaders, representatives of the housing industry, housing advocates, academic experts on housing and public officials. It should be mandated to:

- Review current housing policies and propose statutory and administrative code revisions to facilitate the development of additional housing units.
- Consider the establishment of a permanent ombudsman office to facilitate the coordination and obtaining of necessary permits and licenses for the construction and rehabilitation of appropriate housing.
- Identify innovative methods to more efficiently use existing resources for housing.
- Propose methods of cooperatively involving communities in implementing the mandate of **Mount Laurel II** and other proposals developed to address housing needs.
- Conduct discussions with major public and private financial institutions to identify methods of expanding the pool of private financing for modest-income housing. Financing for both newly constructed units and rehabilitation should be explored. Further, the feasibility of establishing a state secondary mortgage market should be examined.

IV. PROHIBIT DISCRIMINATION

Discrimination against children and their families in access to housing should be statutorily prohibited except with regard to special housing for the elderly. Existing statutes should be amended to prohibit discrimination in the rental or sale of all housing, public and private, on the bases of parental status, marital status, legitimate source of income, age or number of children. In addition, provision should be made to increase the penalties for violation of such laws and to encourage the

Division of Civil Rights and local and state prosecutorial agencies to enforce the laws.

V. MEET HOUSING NEEDS OF VULNERABLE YOUTH

The housing needs of older children and young adults who are leaving their parental homes or being deinstitutionalized are a matter of special concern. Special housing programs should be developed for these individuals which take into account their housing, personal development and service needs.

NOTES

1. Joseph G. Feinberg, (Chief, Bureau of Housing Services, New Jersey Department of Community Affairs), provided estimate, November 18, 1983.
2. *Final Report of the Assembly Housing Emergency Action Team* (HEAT), June, 1981 (chaired by Senator Leanna Brown).
3. *Ibid.*
4. *Ibid.*
5. *Ibid.*
6. George Sternlieb, Robert W. Lake, Richard L. Florida, Robert W. Burchell, W. Patrick Beaton and David Listokin, *Mount Laurel II: Challenge and Delivery of Low-Cost Housing* (Piscataway, NJ: Center for Urban Policy Research, Rutgers University, 1984).
7. *HEAT.*
8. *Ibid.*
9. This is based upon a standard mortgage eligibility formula which assumes that the average household can afford a total mortgage amount of 150 percent of the total average income.
10. This figure is based upon the 150 percent formula.
11. This total was obtained from *Mount Laurel II: Challenge and Delivery.* Low-income households are those with incomes below 50 percent of the region's median income.
12. *South Burlington N.A.A.C.P. v. Mt. Laurel Twp.,* 92 N.J. 158, 209 (1983), (hereinafter Mt. Laurel II).
13. David G. Sciarra, "Statement of the Public Advocate Before the Sub-Committee on Public Housing of the Assembly Committee on Housing and Urban Policy," September 30, 1983, and "Newark Ponders Plight of Its Housing Projects," *The New York Times,* 22 September 1982.
14. Shirley Geismar, *Not Enough to Live On: A Survey of Living Costs and Conditions of Head Start Families in Newark* (Newark, NJ: Newark Preschool Council and the Association for Children of New Jersey, 1984).
15. Stephen Eisdorfer, Esq., "Housing New Jersey's Children," *Association for Children of New Jersey Newsletter,* Vol. VI, No. 5 (September, 1983).
16. Isabel Wolock., Ludwig Geismar, Bruce Lagay and Phyllis Raiffe, *Final Report—Impact of OBRA Policies on AFDC Families: A Study of Middlesex County Families* (New Brunswick, NJ: Rutgers University Graduate School of Social Work, 1984), and Shirley Geismar, Tricia Fagan and Patricia Deignan, *Through the Safety Net: A Citizen's Report on New Jersey Families and Children in Need* (Newark, NJ: Association for Children of New Jersey, 1983). Similar findings were reported in Geismar, *Not Enough to Live On.*
17. Robert W. Marans, Mary Ellen Colten, Robert Groves and Barbara Thomas, *Report on Measuring Restrictive Rental Practices Affecting Families with Children: A National Survey* (Housing and Urban Development, 1980).
18. Eisdorfer, "Housing New Jersey's Children."
19. N.J. STAT. ANN. 4:19-15.2
20. Eisdorfer, "Housing New Jersey's Children."
21. *Report of the Governor's Task Force on the Homeless* (Trenton, NJ: New Jersey Department of Human Services, 1983), p. 14.
22. Carol Williams, Barbara Catterall and Leonard Feldman, *Foster Care Utilization—Metro Region* (Trenton, NJ: New Jersey Department of Human Services, Division of Youth and Family Services, Bureau of Research, Evaluation and Quality Assurance, 1983).
23. Eisdorfer, "Housing New Jersey's Children."
24. Joseph G. Feinberg, (Chief, Bureau of Housing Services, New Jersey Department of Community Affairs), provided information, November 18, 1983.
25. Eisdorfer, "Housing New Jersey's Children."
26. *Report of the Governor's Task Force on the Homeless.*
27. Projected losses include: $400,000 for Section 8 New Construction and Substantial Rehabilitation; $2.6 million for Section 312 Rehabilitation Loans; $13.8 million for Section 502 Home Ownership Loans; $2.9 million for Section 515 Rental Housing Loans; $4.5 million for Operation of Public Housing; $1.2 million for Public Housing; and $5 million for Section 202 Housing for the Elderly as reported by Joseph G. Feinberg, (Chief, Bureau of Housing Services, New Jersey Department of Community Affairs), May, 1983.
28. Sciarra, "Statement of the Public Advocate Before the Sub-Committee on Public Housing of the Assembly Committee on Housing and Urban Policy."
29. Eisdorfer, "Housing New Jersey's Children."
30. *Mt. Laurel II.*
31. Information provided by the New Jersey Department of Community Affairs.
32. *HEAT.*
33. *Ibid.*
34. *Ibid.*
35. N.J. STAT. ANN. 55:14K-1.
36. *HEAT.*

PREVENTIVE AND REMEDIAL HEALTH CARE FOR CHILDREN

This section sets forth recommendations for preventive and remedial health care services for children. The priority issues selected for action include:

- LEAD POISONING
- MEDICAID SERVICES
- MEDICAID COVERAGE FOR THE MEDICALLY NEEDY
- COORDINATION OF HEALTH CARE SERVICES

UMDNJ, George Kemper, Photographer

LEAD POISONING: PREVENTING A SERIOUS THREAT TO NEW JERSEY'S CHILDREN

An estimated 220,000 young children in New Jersey are at risk of lead poisoning. But, screening services are available to test only a small portion of the children at high risk.

- **LEAD POISONING IS A SERIOUS THREAT TO A LARGE PORTION OF NEW JERSEY'S CHILDREN**
- **THE COSTS OF NOT DETECTING AND TREATING LEAD POISONING HAVE BEEN ESTIMATED AT $350,000 PER CHILD**
- **THE SMALL, ACTIVE PROGRAM IN THE STATE HEALTH DEPARTMENT IS NOT IN PROPORTION TO THE MAGNITUDE OF THE PROBLEM**
- **MANDATORY SCREENING IS THE ONLY RESPONSIBLE WAY TO PREVENT LEAD POISONING**
- **NEW JERSEY NEEDS RESPONSIBLE LEAD POISONING SCREENING, TREATMENT AND EDUCATION**

UMDNJ, Dan Katz, Photographer

In 1982, the Commission on Children's Services identified lead poisoning as a major health problem for New Jersey's children. In fact, the Commission's report urged that priority be placed on the problem and the Commission recommended that:

> The Legislature . . . appropriate funds to supplement those available from the federal government to screen all children at risk of lead poisoning. The Department of Health should be directed to develop a plan for implementation of screening services.[1]

LEAD POISONING IS A SERIOUS THREAT TO A LARGE PORTION OF NEW JERSEY'S CHILDREN

Today, lead poisoning continues to pose a serious risk to a large portion of New Jersey's children, and the problem has been identified as possibly being the leading childhood disease in the state. Estimates prepared for 1984 show that 220,000 children in 110 communities are at high risk of lead poisoning. **Further,** as illustrated in Graph 3.3, **New Jersey has some of the highest rates of lead poisoning that have been reported in the nation;** in some localities as many as 14.1 percent of children who are screened evidence elevated lead levels, over **three times** the national average of 4.1 percent.[3]

Lead poisoning can cause devastating physical and intellectual impairments. For example, lead poisoning may result in:

- mental retardation and neurological deficits
- learning disabilities
- behavior dysfunctions
- liver and kidney damage

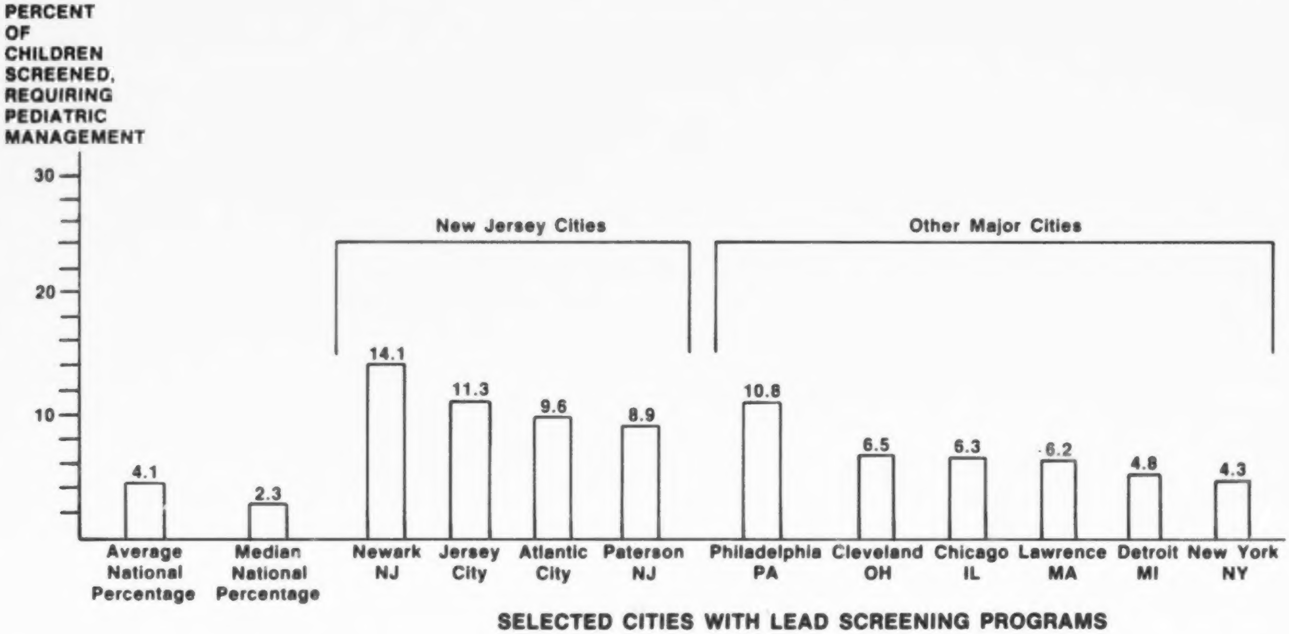
Studies in the medical literature and projects funded through the Center for Disease Control in Atlanta report that damage from lead poisoning is most likely among preschool children and **can occur with or without the child's displaying symptoms.**[4] In the light of this new information, the figure 220,000 may not reflect the true extent of the lead poisoning problems in New Jersey.

The dimensions of the problem are probably larger than the estimates, and they may be increasing. The approximation of 220,000 children at high risk is based on a statistical population-age-of-housing-income formula which is also an estimate.

Every year, medical authorities report that levels of lead in the blood considered "permissible" or "tolerable" the year before are considered toxic this year, and the effects of lead in the blood are continuously being uncovered at younger and younger ages.

Graph 3.3

CHILDREN AFFLICTED WITH LEAD POISONING AS INDICATED BY THE CENTER FOR DISEASE CONTROL'S CHILDHOOD LEAD SCREENING PROGRAM FY '81



From: **Annual Summary 1981, Reported Morbidity and Mortality in the United States, Morbidity and Mortality Weekly Report,** Vol. 30 No. 54, p. 113 (October 1982).

Further, a recent four-year national study found that the prevalence of elevated blood lead levels among children aged six months through 5 years was significantly higher than predicted, and that low-income and Black children in particular showed higher prevalences of elevated blood lead levels.[5]

The 1982 national study lends assistance in targeting populations at greatest risk of lead poisoning but there still remains great concern about the extent of overall risk to young children in general. In fact, the Assistant Surgeon General of the United States issued a memorandum in November, 1982 recommending that all children in the nation aged one through five years be screened for lead poisoning, regardless of socioeconomic class or place of residence.[6]

THE COSTS OF NOT DETECTING AND TREATING LEAD POISONING HAVE BEEN ESTIMATED AT $350,000 PER CHILD

The permanent mental retardation and brain damage of low-level chronic lead poisoning necessitate extensive medical treatment, special education, institutionalization, and other social costs throughout society. Commissioner Shirley A. Mayer, New Jersey Department of Health, stated in 1982: "The cost in medical and special education needs for a child suffering from the neurologic effects of lead poisoning were estimated in 1978 at $350,000."[7] Only early detection and treatment can prevent damage or limit the extent of damage.

THE SMALL, ACTIVE PROGRAM IN THE STATE HEALTH DEPARTMENT IS NOT IN PROPORTION TO THE MAGNITUDE OF THE PROBLEM

In New Jersey, the Department of Health serves as the lead agency for lead poisoning control. Through its Parental and Child Health unit, the department administers a small but very active program which emphasizes screening and treatment services for affected children as well as abatement of leaded properties to remove lead-based paint.

The department, which initiated screening services in 1956, followed up on the Federal Lead Paint Poisoning Prevention Act[8] and related New Jersey laws enacted in 1971[9] by preparing screening guidelines, writing standards for abatement (removal) of lead-based paint, training personnel and conducting epidemiological studies. With federal funds, the department has been providing support for lead poisoning projects in eight "project cities" at an annual cost of about $1.1 million.

Despite the department's efforts, however, only a small portion of the 220,000 children at risk of lead poisoning have been screened on an annual basis. For example, in 1982 the funds were sufficient to screen only 16 percent or 35,531 of the high risk population. In 1983, 12 new projects were started with the aid of federal Jobs Bill funds and the percent of high risk children who received screening services increased to 23 percent. But, these new projects had to be terminated in 1984 when state funding was not provided to replace the Jobs Bill funds.[10] Thus, the state's lead prevention effort has actually diminished since 1983.

The accompanying table summarizes the numbers of children who were screened in recent years and shows that a substantial number of children were found to have elevated levels of lead in their blood or to be at high risk of lead poisoning.

Table 3.1

Numbers of children screened for lead poisoning in New Jersey, numbers found to have elevated blood lead, and numbers found to be at high risk at screening, by year

	Number of Children		
Year	Screened	Elevated*	High risk*
1980. . .	28,397	2,906	1,258
1981. . .	34,028	2,497	1,157
1982. . .	35,534	1,930	658

*Children who have no symptoms are tested for lead in the blood and for a substance in the blood called EP. Combinations of these make up "risk classifications." "Elevated" means risk classifications II, III, and IV; "high risk" means risk classifications III and IV. Testing has to be followed by more complete medical and laboratory examination.

MANDATORY SCREENING IS THE ONLY RESPONSIBLE WAY TO PREVENT LEAD POISONING

Screening is the only way to document the extent of lead poisoning among preschool children in New Jersey. This epidemic is hidden, because lead-poisoned children display no symptoms until too late in most cases, and often display no symptoms at all. Moreover, the negative effects of lead in the blood have recently been reported even for the fetus.[12]

Fortunately, lead poisoning can be prevented, and screening can cause rates of lead poisoning to drop. Lead poisoning can be prevented if a child is screened early enough in life—treatment and the abatement of the source of poisoning in the environment stop the disease. Wherever lead screening is carried out, rates of lead poisoning drop. For example, Chicago reported that the incidence of high blood lead among children who live in screening areas declined from 8.5 percent in 1967 to 3.8 percent in 1968.[13] New York state reports a decline after instituting extensive screening.[14]

CURRENT EFFORTS IN NEW JERSEY AND IN OTHER STATES: BASIC COMPONENTS AND COSTS

There are extensive screening programs outside New Jersey. Massachusetts screens 85 percent of children in Boston and 36 percent of children in the rest of the state: 120,000 children out of a population of 450,000 in the age range, according to Terry Samuels, Director of the Massachusetts Childhood Lead Poisoning Prevention Program.[15] New York City has the largest screening program in the nation: screening 600 per day in 1983, and having screened up to 1,000 per day in 1970, the program reaches 20-30 percent of all children in the age range.[16] Dr. Balkrishena Kaul, Director of the Toxicology Laboratories for the New York City Health Department reported that the city last year screened **about 140,000 children 4 times a year.**[17] The city of Chicago screened 41,563 in Chicago alone in 1980, through 25 infant and maternal welfare stations in the city, according to Dr. Lorry Blanksma, Director of the program for the Chicago Board of Health.[18]

Precise data on projected costs for expanding New Jersey's lead poisoning prevention programs and increasing the number of children screened have not been reported by the Department of Health. The Department spends $1.4 million for lead programs in eight "project cities," and for the other activities. The numbers of children screened for blood lead, to have elevated blood lead, and to be at risk for lead poisoning are shown in the preceding table.

Data from other states suggest that the costs will vary according to these factors:

- Type of test actually used to screen a child for lead poisoning (there are several methods) and number of confirmatory and follow-up tests.
- Emphasis on ancillary services such as follow-up, treatment, abatement, outreach and public education.
- Availability of in-kind services to support the program.
- The extent to which expansion can be accomplished by building upon existing projects or utilizing other agencies as "host" sites for screening projects so as to minimize start-up costs.

SCREENING

Screening is the least expensive component of lead poisoning prevention programs. For example, Massachusetts has reported that it costs about $3.00 per child for an initial screening test which includes analysis of a blood sample.

Some states put screening and parental education ahead of other components, including environmental abatement. For instance, Michael Tatarzewski, Coordinator of Lead Poisoning Control for the New York State Department of Health explained that his program "emphasizes educational home visits for children with mild to moderate lead toxicity while reserving traditional home abatements for children diagnosed with lead poisoning or seriously elevated blood lead levels."[19]

FOLLOW-UP

Programs with follow-up and abatement components cost considerably more. Dr. Terry Samuels, Director of Lead Poisoning Control for Massachusetts, reported that Massachusetts planned to spend $1.4 million last year to screen, follow-up and abate properties for 150,000 children—triple the number currently being served in New Jersey for the same amount of money. Excluding federal funds and in-kind services, the 1983 investment of state funds in preschool children in Massachusetts was $874,000, or about $5.35 per child. Percentages of the dollar spent on lead poisoning prevention by Massachusetts are shown in the following tabulation. Overall, the program costs about $10.00 per child for all services, Dr. Samuels estimated.

Table 3.2
Percentages of the dollar spent on lead poisoning prevention by Massachusetts

Activity	Percent[20]
Total	**100.00**
Inspections and reinspections	21.12
Prevention, education, and screening	20.46
Laboratory for lead analysis	17.26
Legal enforcement	16.42
Epidemiology	9.31
Crisis-intervention deleading	9.00
Case Management	6.40

If New Jersey were able to replicate the Massachusetts model, a program that combines screening, follow-up, and abatement might be provided here for 220,000 children annually at a total cost of about $2.2 million.

ABATEMENT: DIFFICULT TO ENFORCE

Abatement is a most difficult problem. While the law in New Jersey requires landlords to abate properties where lead-poisoned children are identified,[21] enforcement is often difficult. This is one reason why, although the Health Department requires many municipalities to have lead screening programs, only a handful have complied. The municipal health officers fear the costs and political fallout from requirements for abatement. This is the reason why New York state does not require that a property be abated when a child has a blood lead of 49 ug/dcl.[22] Currently, New Jersey requires abatement where a child's blood lead is much lower. The extent to which current state regulations for abatement may impede prevention of the disease by draining off funds to what may be an insoluble problem ought to be investigated.

NEW JERSEY NEEDS RESPONSIBLE LEAD POISONING SCREENING, TREATMENT AND EDUCATION

In light of the grave risk of long-term damage to children, a statewide lead poisoning prevention program is needed to screen, at minimum, all of the children who the Department of Health has identified as being at high risk of lead poisoning. Further, since responsible health care delivery requires that illnesses be treated, the program should include a strong educational component which will teach adults the consequences of lead poisoning, the need for periodic testing especially in the light of the fact that the problem often does not have clear symptoms, and the need for preventive and treatment measures. Such an educational component could be effective in informing adults of the risks of lead poisoning, and encouraging them to obtain services for children in their care.

Since the full extent of lead poisoning among New Jersey's children is not known and the current projections may be well underestimated, a study is needed to assess the problem in New Jersey. A thorough study is also needed to clearly ascertain whether the risk is largely confined to specific population groups, or whether the threat of lead poisoning cuts across different population groups in different geographical locations in New Jersey.

Work needs to be done as well to identify cost-efficient methods of preventing lead poisoning among young children in New Jersey and to develop a statewide strategy to address the problem. This is a responsibility that could be undertaken by an Advisory Council to the Department of Health which could recommend methods to: use the network of local institutions, agencies and programs that serve children to screen children, notify their parents and inform them about needed treatment, and see that follow-up and education are carried out.

The input of physicians, health personnel, parents and service providers from the community is necessary to provide the network effect that is needed to be certain that **all** preschoolers are screened and that children at highest risk are given the priority. Their input is necessary as well to design effective educational programs and materials to create the "critical mass" of awareness that would make lead poisoning symptoms as familiar to parents as are the symptoms of measles.

RECOMMENDED ACTION

MANDATE SCREENING FOR HIGH-RISK CHILDREN

The State should establish a statewide mandatory and comprehensive screening program to screen all children who are at high risk of lead poisoning, to treat those children identified as lead poisoned, and to develop and disseminate educational materials for those who work with children. Further:

A. STUDY TO IDENTIFY RISK TO CHILDREN

The Department of Health should perform a study to assess the full extent of lead poisoning among New Jersey's children, and to identify those population groups which are at high-risk of lead poisoning. This study should use a random sample and appropriate methodology to assess the level of risk among children from different population groups, and, as well, the study should specifically assess the extent to which children living in areas considered low-risk by currently used criteria are in fact affected by lead poisoning. This study should be initiated and completed within the next 15 months.

B. FUNDING

The sum of $1 million should be appropriated to the Department of Health in order to perform the study, and re-open the lead screening programs which were closed due to lack of funding.

C. ESTABLISH ADVISORY COUNCIL

An Advisory Council should be established to guide the development and implementation of an adequate screening program to ensure the screening of all children who are at high-risk of lead poisoning. The Council should also review the results of the Department of Health's study once it has been completed to determine whether the results indicate that all children are at risk and should therefore be screened. Membership of the Council should include representatives of the New Jersey Senate and Assembly, public health physicians, coordinators of municipal childhood lead poisoning prevention programs, physicians who specialize in lead poisoning control, the parents of children at risk of lead poisoning and the Commissioner of Health or his designee.

NOTES

1. R. Alexandra Larson and Carol Kasabach, *Linking Policy with Need* (Trenton, NJ: New Jersey Commission on Children's Services, 1982).
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3. Statistical data on rates of lead poisoning were obtained from the U.S. Department of Health and Human Services, Public Health Service, Center for Disease Control, *Annual Summary 1981, Reported Morbidity and Mortality in the United States, Morbidity and Mortality Weekly Report*, Vol. 30, No. 54 (October, 1982) p. 113. The statistics cover 1981, the last year in which reporting of lead screening was required. We have used the highest percentage of children requiring pediatric management from the programs reporting during Federal Fiscal Year 1981. It should be noted that the 23 percent figure reported for "other local programs" in New Jersey was for only one fiscal quarter, as was the data reported for Elizabeth, New Jersey; Edward Duffy, New Jersey Department of Health, telephone interview, December 13, 1984.
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10. Information provided by the New Jersey Department of Health.
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14. Thomas Kaiser, (Project Coordinator, Lead Poisoning Control Program, New York City Department of Health), telephone interview, September, 1983.
15. Terry Samuels, M.D., (Director of the Massachusetts Childhood Lead Poisoning Prevention Program), telephone interview, September, 1983.
16. Thomas Kaiser, telephone interview, September, 1983.
17. Balkrishena Kaul, M.D., (Director, Toxicology Laboratories, New York City Health Department), telephone interview, September, 1983.
18. Lorry A. Blanksma, Ph.D., (Director of the Chicago Childhood Lead Poisoning Prevention Program), telephone interview, September, 1983.
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22. Michael Tartarzewski, telephone interview, September, 1984. For explanation of blood lead levels see: Centers for Disease Control, "Preventing Lead Poisoning in Young Children," *Journal of Pediatrics*, Vol. 93 (1978) pp. 709-720.

MEDICAID: IMPROVING THE QUALITY OF HEALTH CARE SERVICES

More than 300,000 impoverished children in New Jersey depend upon Medicaid to receive health care services. However, many eligible children do not receive the preventive health care screenings authorized under the Medicaid program, and many are denied necessary medical services because low rates of reimbursement discourage physicians from treating children who are Medicaid patients.

- THE EPDST PREVENTIVE SCREENING PROGRAM IS UNDERUTILIZED
- OUTREACH NEEDED TO INFORM PARENTS
- LOW REIMBURSEMENT RATES IMPEDE SERVICES FOR POOR CHILDREN
- EFFORTS TO IMPROVE THE MEDICAID PROGRAM

UMDNJ, Dan Katz, Photographer

Currently, about 301,354 New Jersey children from impoverished families rely upon Medicaid to receive health care services.[1] In fact, 58 percent of the New Jersey residents enrolled in the state's Medicaid program are children,[2] many of whom have no other means of obtaining health care services.

THE MEDICAID PROGRAM

Supported jointly by state and federal funds, Medicaid is a public health insurance program which pays for both out-patient and hospital care. In New Jersey, only children whose families are eligible for Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) may currently enroll in Medicaid. The program is administered by the Division of Medical Assistance and Health Services (DMAHS) in the Department of Human Services.

ESSENTIAL MEDICAL SERVICES FOR POOR CHILDREN

The preventive and remedial health care services covered by Medicaid are critical for low-income children who are, often by virtue of living conditions and nutritional deficiencies associated with poverty, at higher risk of illness and disabilities.[3] For example: information from federal studies shows that children from families with annual incomes under $5,000 were 3.5 times as likely to be judged in "fair" or poor health when compared with those from families with annual incomes over $15,000.[4] Further, the infant mortality rate is 50 percent higher for low-income children,[5] and low-income children have been found to be 1.5 times more likely to be limited in activities because of chronic health conditions.[6]

EFFECTIVENESS NOT EVALUATED

Despite the importance of Medicaid services for poor children, relatively little has been done to assess their effectiveness in meeting the health care needs of New Jersey's children. While the agency which administers the Medicaid program collects some data on service use, it does not provide data on service appropriateness and effectiveness. Nor does it prepare data on morbidity and mortality statistics for Medicaid recipients.

Tracking and monitoring of service use is done but the data is used primarily for fiscal purposes such as cost containment and prevention of abuse and fraud. Thus, as the Governor's Committee on Children's Ser-

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vices Planning learned, data analysis is not routinely done to monitor the health status of these vulnerable children and to determine whether they are consistently receiving necessary health care services.[7]

THE EPSDT PREVENTIVE SCREENING PROGRAM IS UNDERUTILIZED

Children covered by Medicaid are eligible for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, a series of periodic preventive health screenings that are designed to prevent acute illness. The DMAHS is responsible for directing the EPSDT program.

Studies of the EPSDT program in other states show that it is remarkably effective in reducing overall medical care costs for low-income children. For example, in Missouri participating children had annual medical costs 16 percent lower than the non-participants. In North Dakota, total Medicaid expenditures for screened children were 36-44 percent lower than for other children. Further, the North Dakota study found that expenditures for in-patient hospital services were 47-57 percent lower for the screened children.[8]

However, available statistics suggest that many eligible New Jersey children are not receiving this important preventive service. To illustrate: only 11.6 percent of the eligible children were screened in 1979, ranking New Jersey 36 of the 45 states for whom EPSDT use rates were obtained.[9] And, in 1983 only 10.9 percent of the eligible New Jersey children were screened.[10]

Some of the eligible children may have received medical care through local child health conferences which did not report the service to Medicaid. Others may have received a screening as part of the medical evaluation for an existing condition, and therefore did not require an EPSDT screening. According to DMAHS, about 33 percent of the eligible children receive "equivalent" services.

But while some of the children who did not receive EPSDT screenings receive "equivalent" services, untold numbers of children may be receiving no or inadequate services. Despite the availability of EPSDT as a means of assuring that vulnerable children receive minimal preventive care, EPSDT has not been widely utilized in New Jersey for this purpose.

OUTREACH REQUIRED TO INFORM PARENTS

One inherent difficulty in providing EPSDT services is the method of outreach currently utilized to inform parents of the program. Under the EPSDT regulations, parents of children enrolled in Medicaid must be advised of the program and encouraged to use it. Outreach is currently conducted by the staffs of the county welfare departments and by direct mailings.[11]

NEARLY 60% OF NEWARK HEAD START PARENTS UNAWARE OF EPSDT

However, since the intensity and quality of the outreach effort varies from one county to another, there is no assurance that effective techniques are consistently used to explain the service to parents and to link them with accessible physicians willing to perform the EPSDT screening. In fact, a 1984 study of over 400 Newark families enrolled in Medicaid suggests that many parents are never informed about the EPSDT program. This study, a survey of the families of children enrolled in the Head Start program, found that nearly 60 percent of the parents had never heard of the EPSDT program.[12]

PROBLEMS WITH EXISTING OUTREACH METHODS

Outreach efforts may be impeded by the fact that the county welfare staffs have many other duties and are not equipped to function as health care professionals would in identifying high-risk populations and making a concentrated outreach effort. Additionally, since the county welfare staffs conduct outreach to only those families known to the welfare office and enrolled in Medicaid, no attempt is made to identify those families who may be income eligible but who have not presented themselves at the county welfare office. Thus, many income-eligible families may not even know about the service.

While the outreach procedures used have passed state and federal monitoring, they are, at best, of questionable effectiveness. Further, they are generally not coordinated with health care programs offered by the Department of Health or local health care providers. Additionally, there are serious concerns about placing responsibility for outreach within DMAHS since the agency has an administrative emphasis on fiscal policy and constraints, focuses only on clients already determined eligible, and does not promote vigorous outreach to identify potentially eligible children.

Moreover, although the Department of Health is the primary state agency responsible for planning and coordinating health care services for children at both the state and local levels, it has not been given a major role in the administration of the EPSDT program. Some coordination does occur around the planning and provision of services for EPSDT eligible children, but the Department of Health's extensive linkages with local health care providers have not been widely utilized to improve outreach for the EPSDT program.

LOW REIMBURSEMENT RATES IMPEDE SERVICES FOR POOR CHILDREN

As the Commission on Children's Services found, many physicians will no longer accept Medicaid patients because the reimbursement rates do not cover the actual costs of ambulatory care.[13] Consequently, it is becoming increasingly difficult for children on Medicaid to obtain preventive health care services. And, as a 1983 study by the Association for Children of New Jersey found, poor families cannot find physicians to serve them, and they are inappropriately using hospital emergency rooms for primary, non-emergency care.[14]

Thus, the low rates of reimbursement for out-patient care have had two negative results. Vulnerable children cannot readily receive preventive care before a condition becomes serious and more costly to treat, and there is an overuse of costly hospital services. In both instances, these problems lead to higher overall costs to both the client and the taxpayer which might be avoided by provision of preventive care in a non-hospital setting.[15]

EFFORTS TO IMPROVE THE MEDICAID PROGRAM: THE MEDICAID PERSONAL PHYSICIAN PLAN

The Medicaid Personal Physician Plan, initiated in 1983, is an attempt to institute a physician case management plan for those enrolled in Medicaid. Piloted in Warren, Morris and Sussex counties, the plan was recently expanded to Mercer, Middlesex, Burlington, Atlantic and Camden counties. The project is theoretically an improvement in Medicaid service delivery since it establishes comprehensive and continuing care from one medical provider.

The project is also designed to result in fiscal savings since it is intended to provide lower cost care directly from a physician. It is anticipated that the participating clients will rely less on expensive emergency room care.

Further, since the capitation schedule used for payment of physicians participating in the plan is greater for young children,[16] it may result in the reduced use of emergency rooms as the primary health care provider for enrolled children. However, the long-range success of the project in achieving this goal is in part dependent upon whether the rates of reimbursement prove sufficient to involve an adequate number of pediatricians in the project on an on-going basis.

USE OF HMOs

A second approach to providing comprehensive health care for Medicaid recipients and avoiding the high costs of inappropriate emergency room treatment is through use of Health Maintenance Organizations (HMO). HMO's deliver and finance comprehensive health care services to clients who elect to enroll in their plan. Services are provided for, on a pre-paid capitation fee.

In March, 1983 Omnicare/the HMO in Cumberland County began accepting Medicaid recipients.[17] As of June 1984 the services of Omnicare/the HMO have been expanded to provide services for Medicaid families who are residents of Cape May and Atlantic counties,[18] and 700 Medicaid recipients are enrolled in the program. Omnicare/the HMO is paid a monthly fee of $47.80 per client in exchange for the services that may be required.[19]

RECOMMENDED ACTIONS

I. VIGOROUS OUTREACH AND PROVISION OF EPSDT—REASSIGN TO DEPARTMENT OF HEALTH

The outreach and screening functions of the EPSDT program should be transferred from the Department of Human Services, DMAHS to the Department of Health. The Department of Health should be directed to administer these functions as part of its overall responsibility for planning and coordinating state and local health services for children. Further:

A. **These functions should be carried out in an advocacy manner designed to prevent unnecessary maladies in children** and to prevent the need for expensive emergency treatment.

B. **The Department of Health should implement a plan to accomplish 100 percent enrollment of all children eligible for Medicaid in the EPSDT program.** The Department's implementation plan should utilize all available state and community resources, augmented where necessary and orchestrated on the local level by the Department.

II. EVALUATE SERVICE EFFECTIVENESS

Data should be collected and analyzed in order to evaluate the efficacy of the Medicaid program and its services for children.

III. ESTABLISH COMPREHENSIVE PREVENTIVE HEALTH CARE PROGRAM

DMAHS should work cooperatively with physicians to establish an appropriately comprehensive and continuing program of preventive health care for the children of New Jersey.

IV. EVALUATE ADEQUACY OF MEDICAID REIMBURSEMENT RATES

The state should evaluate the adequacy of current Medicaid rates of reimbursement to physicians for health services for children, and readjust the rates to the extent necessary to assure that physicians receive a reasonable fee for the services.

NOTES

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3. Children's Defense Fund, *Paying Children's Health Bills* (Washington, DC: 1982); Margaret A. McManus, M.H.S. and Stephen M. Davidson, Ph.D., *Medicaid and Children: A Policy Analysis* (Evanston, IL: American Academy of Pediatrics, 1982), M.G. Kovar and D.J. Meny, *The Report of the Select Panel for the Promotion of Child Health,* Vol. III, *A Statistical Profile,* Department of Health and Human Services (PHS) Publication No. 79-55071 (Washington, DC: U.S. Government Printing Office, 1981); and Children's Defense Fund, *American Children in Poverty* (Washington, DC: 1984).
4. Kovar and Meny, *The Report of the Select Panel for the Promotion of Child Health.*
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No. 79-55071 (Washington, DC: U.S. Government Printing Office, 1981).

6. Kovar and Meny, *The Report of the Select Panel for the Promotion of Child Health.*
7. The state has not established a system to systematically examine the need for and adequacy of Medicaid services for impoverished children.
8. Children's Defense Fund, *Paying Children's Health Bills,* pp. 33-35.
9. McManus and Davidson, *Medicaid and Children: A Policy Analysis.*
10. Based upon statistics reported by the New Jersey Department of Human Services to the U.S. Department of Health and Human Services for 1983 in "Statistical Report on Medical Care: Recipients Payments and Services," Health Care Financing Administration Form 2082. This report shows that of the 357,672 Medicaid recipients between the ages of birth to 20 years, 38,954 were screened, January, 1984.
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12. Shirley Geismar, *Not Enough to Live On: A Survey of Living Costs and Conditions of Head Start Families in Newark* (Newark, NJ: Newark Pre-School Council and Association for Children of New Jersey, 1984).
13. R. Alexandra Larson and Carol Kasabach, *Linking Policy with Need* (Trenton, NJ: New Jersey Commission on Children's Services, 1982).
14. Shirley Geismar, Tricia Fagan and Patricia Deignan, *Through the Safety Net: A Citizen's Report on New Jersey Children in Need* (Newark, NJ: Association for Children of New Jersey, 1983).
15. J. Holahan, *A Comparison of Medicaid and Medicare Reimbursement Rates—Draft Report to the Health Care Financing Administration* (Grant No. 95-P-9178/3, March, 1982).
16. The capitation fee schedule has been developed to reimburse a physician for case managing and providing services to Medicaid clients who choose membership in the Personal Physician Plan. This schedule of rates takes into account the specific needs of clients by sex and age as well as the specific regional costs for providing services by the client's county. For specific details or more information contact the Personal Physician Plan, Division of Medical Assistance and Health Services of the Department of Human Services.
17. Daniel M. Walsky, (Supervising Program Development Specialist, New Jersey Department of Human Services, Division of Medical Assistance and Health Services), telephone interview, July 18, 1984.
18. New Jersey Department of Human Services, Division of Medical Assistance and Health Services, *New Jersey Health Services Program Newsletter,* Vol. BC 279 (June, 1984).
19. Daniel M. Walsky, telephone interview, July 18, 1984. There are a number of services which are not provided under the Omnicare/the HMO Plan, however these services are provided for on a fee per service basis. These services are: dental services, prosthetic and orthotic appliances, medical supplies and equipment medical daycare, invalid coach and hearing aids. New Jersey Department of Human Services, Division of Medical Assistance and Health Services, *New Jersey Health Services Program Newsletter,* Vol. BC 279 (June, 1984).

MEDICAID COVERAGE FOR THE MEDICALLY NEEDY

New Jersey's current Medicaid eligibility guidelines are based upon very stringent income guidelines which exclude thousands of families whose incomes are below the poverty level. An estimated 100,000 New Jersey children from impoverished families do not meet the current criteria for Medicaid eligibility, and these children may not be receiving necessary medical and dental services because their parents cannot afford to pay for the services. Further, many impoverished pregnant women cannot qualify for Medicaid and do not receive proper prenatal care because they cannot afford to pay for the services.

- IMPOVERISHED CHILDREN HAVE UNMET HEALTH CARE NEEDS AND A HIGHER RISK OF ILLNESS
- MANY POOR CHILDREN ARE EXCLUDED FROM MEDICAID COVERAGE
- FEDERAL OPTION TO COVER THE MEDICALLY NEEDY HAS NOT BEEN USED
- RESTRICTIVE AFDC GUIDELINES NOW MAKE FEWER POOR CHILDREN ELIGIBLE
- INCREASING NUMBER OF POOR CHILDREN DEPRIVED OF HEALTH CARE SERVICES
- LACK OF CARE IS LEADING TO SERIOUS MEDICAL AND DENTAL CONDITIONS
- FEWER PREGNANT MOTHERS RECEIVING EARLY PRENATAL CARE
- COSTLY OVERUSE OF HOSPITAL CARE
- SUBSTANTIAL SAVINGS FROM PREVENTIVE HEALTH CARE
- NEED TO ADDRESS PARENTS' HEALTH CARE PROBLEMS

UMDNJ, George Kemper, Photographer

Health Care is an essential preventive and corrective service for children, especially low-income children who are at a higher risk of illness and disabling health problems.[1] However, according to estimates prepared by the Department of Human Services (DHS), there are 100,000 New Jersey children from impoverished families who may not be receiving necessary medical and dental care because their parents cannot afford to pay for the services.[2]

Further, an estimated 3,000 impoverished pregnant women may not be receiving prenatal care at critical stages early in their pregnancies because they do not have the funds for services and are ineligible for Medicaid.[3] Consequently, children born to these women are at higher risk of being underweight, malnourished or subject to developmental disabilities which might have been prevented by prenatal care.

UNMET HEALTH NEEDS AND HIGHER RISK OF ILLNESS

National data demonstrates the extent of unmet health care needs among low-income children:

- One out of every 60 infants born in the United States dies, a rate higher than in 15 other countries. As recently as 1980, minority infants were twice as likely to die in the first year of life as non-minority children.
- As recently as 1976, 1.3 million American children under 17 had never visited a physician. One out of every three children under the age of 17 (more than 18 million) had never been to a dentist.
- Some 34 percent of the nation's poorest children (4.2 million) have no health insurance. Another 41 percent are insured for only part of each year through Medicaid or private insurance.[4]
- Low-income children suffer more illness and are more at risk of dying than other children.[5] For example, a recent study conducted by Children's Memorial Hospital in Chicago found that: "Poor children have a 75 percent greater chance of being admitted to a hospital in a given year, and their average length of hospitalization is twice as long."[6] And, a recent Maine study showed that children from low-income families die at a rate three times that of other children.[7]

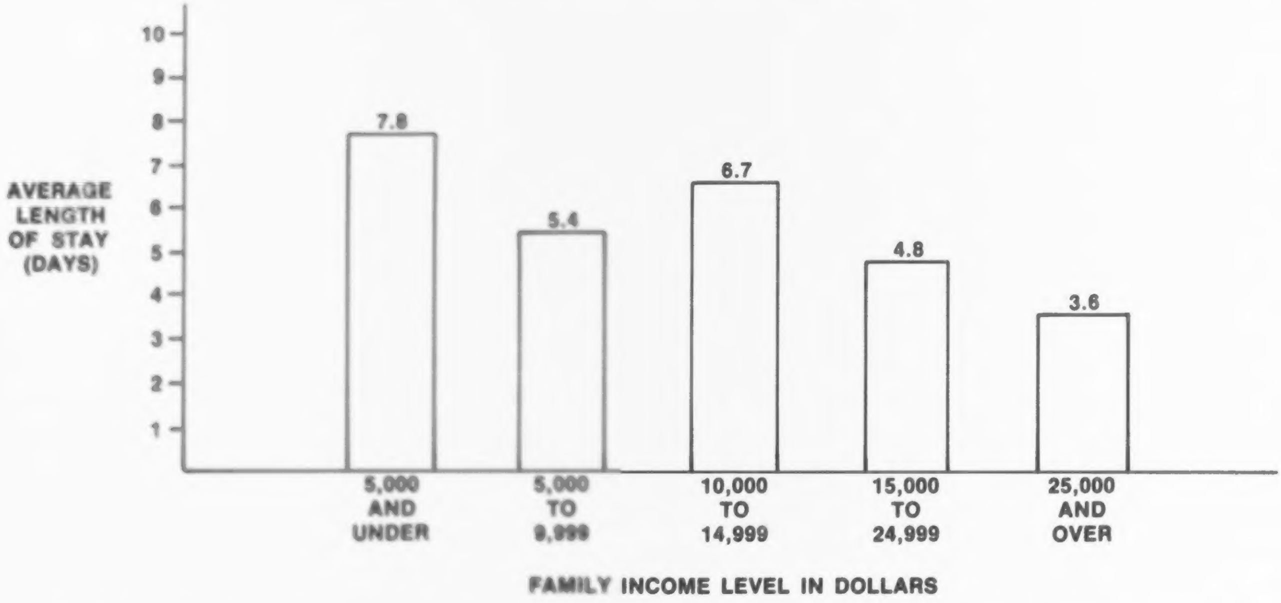
The extent of risk to poor children and patterns of longer, more costly, hospital care were documented by a 1977 national study. As illustrated in Graph 3.4, children from families with annual incomes of $5,000 and below, had the longest average length of stay in hospitals.

MANY POOR CHILDREN EXCLUDED FROM MEDICAID COVERAGE

New Jersey children whose families are eligible for Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) can receive free health care services through Medicaid. However, basing Medicaid eligibility on the very stringent income guidelines used for AFDC results in excluding thousands of families whose annual incomes are below the level required to meet just minimum basic needs

Graph 3.4

LENGTH OF STAY IN HOSPITAL FOR CHILDREN FROM FAMILIES OF DIFFERENT INCOME LEVELS, U.S., 1977



From: U.S. Committee on Interstate and Foreign Commerce, Child Health Assurance Act of 1979 (Washington, DC: Government Printing Office, 1979) p. 34

in New Jersey. For example, the AFDC annual income eligibility limit for a family of four is $7,973, a full 35 percent less than the $12,192 annual income required for a family of four in New Jersey to meet basic necessities of life on a minimally adequate standard of living.[8]

Further, the current eligibility guidelines are more than $2,000 or 22 percent below the federal poverty guidelines, i.e., $10,200 for a family of four. Thus, **even families whose annual incomes are substantially less than the federal poverty guidelines will not qualify for Medicaid.**

FEDERAL OPTION FOR FUNDING COVERAGE FOR MEDICALLY NEEDY

Federal regulations do permit states to extend federally matched Medicaid coverage to other low-income population groups who, although they are not income-eligible for AFDC, are "medically needy" by virtue of low income. At least 30 states provide coverage for the medically needy.[9]

FEDERAL OPTION NOT EXERCISED IN NEW JERSEY

But, since New Jersey has not exercised its option to extend Medicaid coverage to the medically needy, only the poorest of the poor have been granted coverage. And, few impoverished families can afford to purchase private health insurance. To illustrate the point: A family of four living at the poverty level of $10,200 would have to spend $941 annually or 9 percent of its total income simply to buy the cheapest coverage available for Blue Cross; the most comprehensive plan would cost $1,456 or nearly 15 percent of the family's annual income.[10]

RESTRICTIVE AFDC GUIDELINES NOW MAKE FEWER POOR CHILDREN ELIGIBLE

Further, as a result of the new, more restrictive AFDC guidelines enacted under the 1981 Omnibus Budget Reconciliation Act, thousands of low-income families previously eligible for both AFDC and Medicaid benefits have been denied them. In fact, in the first year following the AFDC revisions, there were 18,500 fewer New Jersey children enrolled in Medicaid than had been the prior year,[11] and as many as 40,000 children may have been removed from Medicaid.[12]

Since eligibility standards for Medicaid have not been regularly adjusted for inflation, families today must actually be poorer in terms of the real value of their income in order to qualify for the program. As a result, a smaller percentage of poor children than before are eligible for Medicaid. And, according to a study commissioned by the American Academy of Pediatrics, "(t)his trend will worsen unless the current eligibility standards are raised."[13]

INCREASING NUMBER OF POOR CHILDREN DEPRIVED OF HEALTH CARE SERVICES

While comprehensive data do not exist, available New Jersey studies indicate health care is placing an increasing number of children at risk of serious health problems. For example, a 1984 Rutgers Graduate School of Social Work study of families who lost their Medicaid coverage when terminated from the AFDC program found that:

- 56 percent did not have medical insurance coverage for the children.
- 78 percent of the families reported at least one medical or dental problem for which they could not obtain professional care or follow-up treatment because of the cost.
- 49 percent could not afford care for a child's severe medical problem.
- Almost one-third of the families were unable to provide eyeglasses or dental care for their children.

Although they were ineligible for AFDC assistance, over half of these families had incomes below the poverty level. Many families had to use almost all of their income just to pay for housing and food, and consequently could not pay for private medical care.[14]

LACK OF CARE LEADING TO SERIOUS MEDICAL AND DENTAL CONDITIONS

Further, a 1983 study conducted by the Association for Children of New Jersey found that:

- Hospitals were seeing more minor problems that have escalated into crisis situations because treatment was not sought soon enough.
- Schools and local health departments reported severe untreated dental problems among many school-age children.[15]

FEWER PREGNANT MOTHERS RECEIVING EARLY PRENATAL CARE

Although prenatal care is one of the most important preventive health care measures for children, the number of pregnant women receiving early prenatal care has decreased in New Jersey over the past three years.[16] The problem tends to be particularly pronounced in the urban areas; for example, in 1980 alone as many as 30 percent of the pregnant mothers in nine major New Jersey cities did not receive prenatal care in the first trimester.[17]

Further, the available data show that of the 98,746 births in New Jersey in 1983, over 25 percent of the mothers did not receive adequate prenatal care. Over 1,100 of the babies born in 1983 died within the first year of life, and the overall infant mortality rate for the state was 11.3 per 1,000 live births, a rate well over the national average of 10.9 and a rate higher than the 1981 New Jersey rate of 10.6.[18]

COSTLY OVERUSE OF HOSPTIAL CARE

When their medical problems can no longer be ignored, many poor people who are not eligible for Medicaid turn to hospitals, particularly those in the large inner cities, where they receive costly hospital care and leave behind a trail of "uncompensated" bills. In fact, the ACNJ study found that hospital emergency rooms were being used as primary health care clinics.[19]

In New Jersey, "uncompensated" care for the poor is paid for through the hospital rate setting mechanism under Chapter 83.[20] Current information on uncompensated care use for New Jersey is not available. However, based upon the recent experience of other states, it is highly probable that New Jersey costs are increasing. And, some of these costs would be covered by federal matching funds if the patients were enrolled in Medicaid.

FUNDS NEEDED TO EXTEND MEDICAID COVERAGE

According to estimates prepared by the New Jersey Department of Human Services, the annual state cost of providing limited Medicaid coverage to 100,000 children whose families' incomes are not greater than 133 and 1/3 percent of the appropriate AFDC standard of need ($10,604 for a family of four) would be $18 million. This would include only the minimum services required by federal regulation and would not include services such as in-patient hospitalization, medical supplies, home health services and psychological, podiatric or chiropractic services.

Provision of coverage for the full range of permissible Medicaid services would cost the state $28 million. To extend coverage to 3,000 pregnant women so that they could receive prenatal and delivery services would cost $1.3 million.

SUBSTANTIAL SAVINGS FROM PREVENTIVE HEALTH CARE

Numerous studies have documented that health care services, especially preventive services, for children are highly cost-effective and result in substantial long-term savings for both medical and other services necessary to maintain impaired or handicapped individuals. For examples, it costs $380 annually to care for a child who receives regular preventive care but $640 annually for a child who does not receive preventive care.[21]

LOWER MEDICAL COSTS WHEN PREVENTIVE SCREENINGS PROVIDED

Further, many studies have found that total Medicaid expenditures per child for children who receive preventive screenings were substantially lower than those for unscreened children. To illustrate: a Texas study showed that for every state dollar spent, more than $8 was saved in the long-term costs and income loss avoided.[22]

NEED TO ADDRESS PARENTS' HEALTH CARE PROBLEMS

Provision of Medicaid coverage for low-income children would eliminate a major barrier to their receiving necessary health care services. But, many of their parents will still be unable to have their own health care needs met.

In many instances, the untreated medical problems of these parents will result in placing health, emotional and financial stresses upon the entire family with negative consequences for the children. Extending Medicaid coverage to the whole family would alleviate many of these problems, thereby assuring that children are not indirectly harmed by their parents' untreated medical problems.

RECOMMENDED ACTION

The State should establish a Medically Needy Program providing Medicaid coverage for all children whose families' incomes are below the level required for a minimally adequate standard of living in New Jersey. The Medically Needy Program should also provide Medicaid coverage for pregnant women within the same income level.

NOTES

1. Children's Defense Fund, *Paying Children's Health Bills* (Washington, DC: 1982) and Margaret A. McManus, M.H.S. and Stephen M. Davidson, Ph.D., *Medicaid and Children: A Policy Analysis* (Evanston, IL: American Academy of Pediatrics, 1982).
2. The New Jersey Department of Human Services has estimated that there are 100,000 children whose families have incomes below 133 and 1/3 percent of the Aid to Families with Dependent Children (AFDC) standard of need. The incomes of these families, while too high to qualify them for AFDC, are less than the Federal poverty guideline. The Department's estimate also includes those families whose total medical expenses exceed the amount of that portion of their income which is in excess of 133 and 1/3 percent of the AFDC standard of need. Thus, even families whose incomes exceed the eligibility criteria are considered medically needy when their medical expenses consume their excess income.
3. In order to obtain Medicaid coverage, the woman's income cannot be more than $273 a month ($3,276 annually).
4. Children's Defense Fund, *Paying Children's Health Bills.*
5. M.G. Kovar and D.J. Meny, *The Report of the Select Panel for the Promotion of Child Health,* Vol. III, *A Statistical Profile,* Department of Health and Human Services (PHS) Publication No. 79-55071 (Washington, DC: U.S. Government Printing Office, 1981) and D.B. Dutton, "Children's Health Care: The Myth of Equal Access," *The Report of the Select Panel for the Promotion of Child Health,* Vol. IV., *Background Papers,* Department of Health and Human Services Publication No. 79-55071 (Washington, DC: U.S. Government Printing Office, 1981).
6. John Bisaha, M.A., Katherine K. Christoffel, M.D., M.P.H. and A. Todd Davis, M.D., "Medicaid Cutbacks Influencing Emergency Room Utilization Reflects Reduction In Health Care For Children," *Lifeline,* Vol. 5, No. 5 (October, 1983).
7. Maine Department of Human Services, *Children's Deaths in Maine, 1976-1980* (1983). This study defined "low-income" children as those who received AFDC, Food Stamp and/or Medicaid services. The children studied included those aged 8 days to 17 years who died between the years 1976-1980. It is possible that had the population sample included those children who died between birth and 7 days of age, the rates of death found for low-income children would have been even higher.

8. National Social Science and Law Project, *The Cost of An Adequate Living Standard in New Jersey* (Washington, DC: 1980). This represents an "unmistakably conservative estimate of a minimally adequate standard of living."
9. The states with Medically Needy Programs include: Arkansas, California, Connecticut, Hawaii, Illinois, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nebraska, New Hampshire, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, Utah, Vermont, Virginia, Washington, Washington, DC, West Virginia, and Wisconsin.
10. These were the rates effective in April, 1984.
11. Shirley Geismar, Tricia Fagan and Patricia Deignan, *Through the Safety Net: A Citizen's Report on New Jersey Children and Families in Need* (Newark, NJ: Association for Children of New Jersey, 1983).
12. Ciro A. Scalera, (Executive Director, Association for Children of New Jersey), testimony before the Assembly, Revenue, Finance and Appropriations Committee, July 12, 1984.
13. Margaret A. McManus, M.H.S. and Stephen M. Davidson, Ph.D., *Medicaid and Children: A Policy Analysis.*
14. Isabel Wolock, Ludwig Geismar, Bruce Lagay and Phyllis Raiffe, *Draft, Impact of OBRA Policies on AFDC Families: A Study of Middlesex County, New Jersey.* Presented at Annual Meeting of the Eastern Sociological Society, March 10, 1984; Isabel Wolock, "Testimony Before the Assembly Corrections, Health and Human Services Committee," March 15, 1984. This study was conducted at the Research Center of the Graduate School of Social Work, Rutgers University, New Brunswick, NJ; and Shirley Geismar, *Not Enough to Live On: A Survey of Living Costs and Conditions of Head Start Families in Newark* (Newark, NJ: Newark Pre-School Council, Inc. and Association for Children of New Jersey, 1984). This survey of low-income families in Newark found that 30 percent of the families who did not have Medicaid coverage had not sought medical care for a sick child because they could not pay for it.
15. Geismar, Fagan and Deignan, *Through the Safety Net.*
16. *Children's Defense Fund, American Children in Poverty* (Washington, DC: 1984).
17. Data provided by the New Jersey Department of Health.
18. *Ibid.*
19. Geismar, Fagan and Deignan, *Through the Safety Net.*
20. N.J. STAT. ANN. 26:2H-1 to -18.3.
21. Children's Defense Fund, *American Children in Poverty* (see pp. 33-35 for findings from a number of different studies).
22. *Ibid.*

COORDINATION OF HEALTH CARE SERVICES

Numerous state and local agencies are involved in providing health care services for New Jersey's children. However, no single entity operates to coordinate the planning and provision of these services so that maximum use can be made of existing resources for health care.

- **AT LEAST FOUR DIFFERENT DEPARTMENTS PROVIDE HEALTH CARE SERVICES**
- **NO SINGLE ENTITY COORDINATES EFFORTS**
- **ON-GOING STATE LEVEL MECHANISM NEEDED**
- **STEPS ALSO NEEDED TO IMPROVE INTRA-DEPARTMENTAL COORDINATION**

UMDNJ, George Kemper, Photographer

Numerous state and local agencies currently bear some responsibility for meeting the health care needs of New Jersey's children. But, currently an effective mechanism is not in place to bring the many different agencies together on a consistent basis to plan and coordinate health care services.[1]

AT LEAST FOUR DIFFERENT DEPARTMENTS PROVIDE HEALTH CARE SERVICES

At the state level, at least four different departments play a role in the planning and/or delivery of health care services. Further, within individual departments two or more separate units may be responsible for identifying and meeting children's health care needs.

For example, the Department of Health (DH) has a Parental and Child Health Services unit which is responsible for preventive health care for children. This unit is involved in addressing the problem of infant mortality, developing programs to screen children for lead poisoning and to reduce diseases in children and mothers, arranging services for the medically indigent, assuring access to quality medical services for handicapped children, promoting family planning services, and for improving regional and local health services. The Department's Division of Epidemiology and Disease Control also delivers health services for children through local health departments.

The Department of Human Services (DHS) also has a major responsibility for providing health care services for children. Through its Division of Medical Assistance and Health Services (DMAHS), DHS provides Medicaid coverage for over 300,000 impoverished children so that they may obtain medical and dental services. Within DMAHS, the Bureau of Child Health is responsible for implementation of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program which provides preventive services for Medicaid eligible children.

Additionally, through its Divisions of Youth and Family Services (DYFS), Mental Retardation (DMR), and Mental Health and Hospitals (DMHH), DHS serves many children who require health care services which often must be arranged with the assistance of DHS staff. Often, through their work with children and families, DHS staff are in a particularly advantageous position to identify unmet health needs in certain population groups and, as well, to spot gaps in the overall delivery of services.

The Department of Education (D. of Ed.) is responsible for preparing regulations for the school health services provided by local school districts. This responsibility is carried out by the Division of General Academic Education's Office on School Health. The services which currently must be provided by the local school districts include:

1) Collection of medical examination for athletics and immunizations
2) Annual screening for vision and hearing acuity and scoliosis
3) Tuberculosis testing in districts designated "high risk" by the Department of Health

The Department of Corrections (DOC) also has some involvement in providing health care services for children. DOC must see that children and youth who have been committed to its care receive appropriate health care services, and DOC must also work with other agencies to obtain needed services for this population.

At the local level, agencies involved in providing health care services for children may include:

1) Municipal health departments
2) Local health clinics and child health conferences
3) Schools
4) County Welfare Boards which screen children for Medicaid eligibility and are required to provide outreach to inform families of the EPSDT program[2]

NO SINGLE ENTITY COORDINATES EFFORTS

While considerable efforts are made at both the state and local levels to coordinate health care services for children, no single entity operates to see that joint planning and provision of services is done on a consistent basis. Further, the various responsible agencies do not work together on a consistent basis to identify major gaps in services, and to assess and monitor the overall health needs of New Jersey's children.

Moreover, interviews with state department officials have disclosed that the special health care needs of children are sometimes given low priority when health care is not the administrative unit's primary responsibility or when the program for children is an extension of one operated essentially for adults. Additionally, even within the same department, coordination among the different units which have some responsibility for children's health care services does not always effectively occur.

ON-GOING STATE LEVEL MECHANISM NEEDED

To bring about improved planning, coordination and monitoring of health care services for children, there is a need to establish an on-going state level mechanism which would bring together experts from the various departments and relevant community groups. Such a mechanism could be utilized to provide a common meeting ground for the administrators of different departments responsible for meeting children's health care needs, allow the exchange of information about services gaps and service delivery problems, and encourage joint planning to resolve major unmet needs and service delivery problems.

Two examples of such entities are the Developmental Disabilities Council and the Committee for the Education of the Handicapped. Both entities have worked to improve communication among the departments and to facilitate coordination.

STEPS ALSO NEEDED TO IMPROVE INTRA-DEPARTMENTAL COORDINATION

There is also a need to take steps to improve the internal planning and coordination of health care services within individual departments where responsibility for services is carried by several different units. Where possible, this would best be accomplished by giving a single unit within the department responsibility for the administration of all health care services provided by that department for children. The use of an intra-departmental committee focused on children's health care issues would be an alternative method that could be utilized to unify the different health care services provided by the department, and to facilitate departmental planning on specific health care issues and service delivery problems.

RECOMMENDED ACTIONS

I. INTER-DEPARTMENTAL COORDINATION

Through the proposed Governor's Commission for Children and Youth (see Chapter VI), a standing Inter-Departmental Committee on the Health Status of New Jersey's Children should be established and chaired by the Commissioner of Health. This Committee should have at least two members who are not state government staff, and it should:

- Assess and monitor the health status of children served by the various state agencies
- Identify problems and gaps in the delivery of health care services for children
- Assess and monitor the overall health care needs of children in the context of the family and society
- Quantify the outcomes of services wherever possible

- Make recommendations for policies, planning and procedures to alleviate gaps in services and improve service delivery

Further, this Committee should be required to prepare an annual report to the Governor on the Health Status of Children in New Jersey.

II. INTRA-DEPARTMENTAL COORDINATION

The Departments of Health, Human Services, Education and Corrections should organize their respective units which address children's health issues into a single administrative unit wherever feasible. Where this is not possible, an Intra-Departmental Committee should be established to assure internal coordination of services, avoid duplication of effort, identify systems issues and develop recommendations for broad action by the Inter-Departmental Committee.

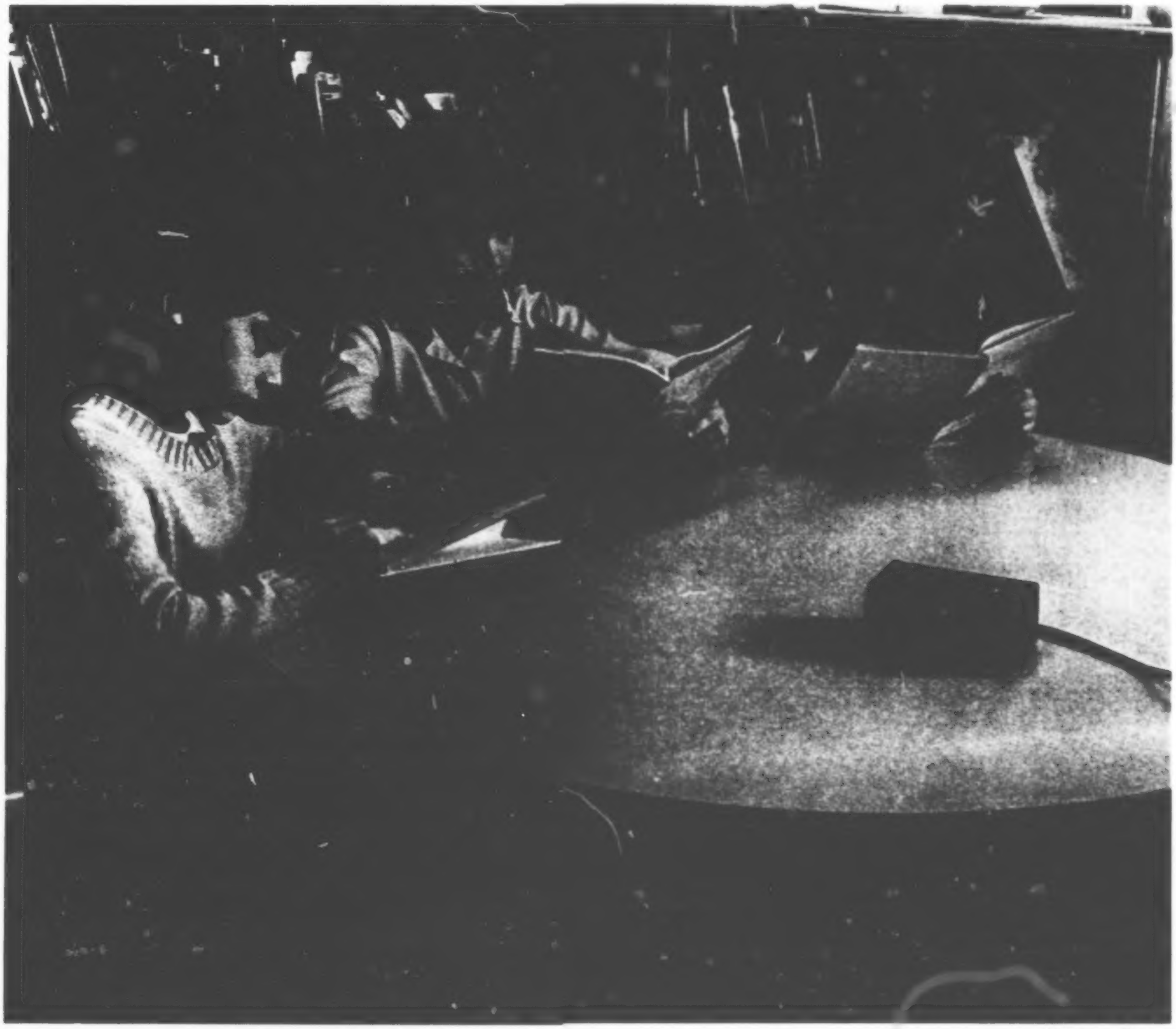
NOTES

1. This problem was highlighted in the report of the New Jersey Commission on Children's Services which recommended that a state plan for coordination and possible consolidation of children's health services be developed, *Linking Policy with Need* (Trenton, NJ: New Jersey Commission on Children's Services, 1982), p. 23, and chpt. IV.
2. Much of the foregoing information on the roles of the different departments and agencies in providing health care services for children was derived from *Linking Policy with Need*, chpts. III and IV.

MEETING EDUCATIONAL NEEDS

This section focuses on those issues which affect the quality of educational services for New Jersey's children. Five issues were selected for action:

- FINANCING PUBLIC SCHOOL EDUCATION
- SCHOOL SUSPENSION PRACTICES AND POLICIES
- UNDER-ENROLLMENT OF HISPANIC SCHOOL-AGE CHILDREN
- FUNDING FOR EDUCATION OF CHILDREN IN STATE FACILITIES
- EDUCATIONAL SERVICES FOR CHILDREN IN COUNTY RESIDENTIAL FACILITIES



Princeton Packet

FINANCING PUBLIC SCHOOL EDUCATION

The current formula for funding public school education has led to grave disparities among New Jersey's school districts in the quality of educational services provided for the state's children. These disparities impact most severely upon poor and minority children in the urban school districts.

- DISPARITIES AMONG SCHOOL DISTRICTS INCREASING
- WIDE VARIATIONS IN PER PUPIL EXPENDITURES
- WEALTHIER DISTRICTS HAVE MORE STAFF
- STUDENTS WHO MOST REQUIRE SERVICES CONCENTRATED IN LOWEST-WEALTH DISTRICTS
- COMMITMENT AND TECHNICAL EXPERTISE NEEDED TO REVISE THE FORMULA

Princeton Packet, Andrea Kane, Photographer

The current formula for funding public school education was mandated by the Public School Education Act of 1975, Chapter 212, in response to the New Jersey Supreme Court's 1973 decision in *Robinson v. Cahill.*[1] In deciding *Robinson,* the Supreme Court held that the existing system for financing education was unconstitutional and found that the quality of education in New Jersey depended too much on the property wealth of local school districts. Further, the Supreme Court found that there was a clear relationship between the quality of services a school district provides, how much it spends on educational services and the amount of its property wealth.

CURRENT FUNDING FORMULA CHALLENGED

Chapter 212 was intended to correct the inequities which stemmed from basing funding of education on property wealth. However, Chapter 212 has not succeeded in alleviating the funding inequities and it is now being challenged on constitutional grounds in *Abbott v. Burke.*[2]

DISPARITIES AMONG SCHOOL DISTRICTS INCREASING

Despite the implementation of Chapter 212, property wealth remains a major factor in determining how much districts spend on education.[3] According to a 1983 analysis, there are significant variations in the distribution of property wealth per pupil among New Jersey's school districts. As illustrated in Graph 3.5, the disparities among districts have increased. For example: in 1975-76, the district at the 95th percentile of wealth had 5.5 times the per pupil valuation of the district at the 5th percentile. By 1981-82, the difference had risen to 8.6.[4]

WIDE VARIATIONS IN PER PUPIL EXPENDITURES

Further, there are wide variations among districts in the dollars they spend for education, and these variations are strongly related to property wealth. As a local school district's property wealth rises, per pupil expenditures rise. State aid is not sufficient to offset the wealth-related disparities in education. For example: in 1981-82 the lowest wealth districts raised only $1,219 per pupil for each dollar of school tax rate as compared with $3,429 per dollar raised by the wealthiest group of districts.[5]

The variations in expenditures are becoming greater and substantial numbers of children are being affected.

In 1975-76, a district in the 95th percentile spent $900 more per pupil annually than a district at the 5th percentile of wealth. By 1981-82, the difference in per pupil expenditures had reached $1,509.[6]

WEALTHIER DISTRICTS HAVE MORE STAFF

The expenditure disparities among New Jersey's school districts lead to significant differences in the size, mix, experience and salaries of the professional staff employed by the districts. To illustrate: the highest spending districts have, on the average, 30 percent more total staff per 1,000 pupils than the lowest spending districts.[7]

Minority children are especially likely to be affected by these disparities. About 70 percent of New Jersey's minority students attend school in the lowest wealth districts.[8]

STUDENTS WHO MOST REQUIRE SERVICES CONCENTRATED IN LOWEST-WEALTH DISTRICTS

Further, students requiring compensatory and bilingual education are concentrated in the lowest wealth districts as are the majority of the students who have not mastered minimum basic skills. In fact, the enrollments of the lowest wealth districts are, on the average, 50 percent low-achieving and 8 percent bilingual as compared with 8 percent low-achieving and one percent bilingual in the highest wealth districts.[9]

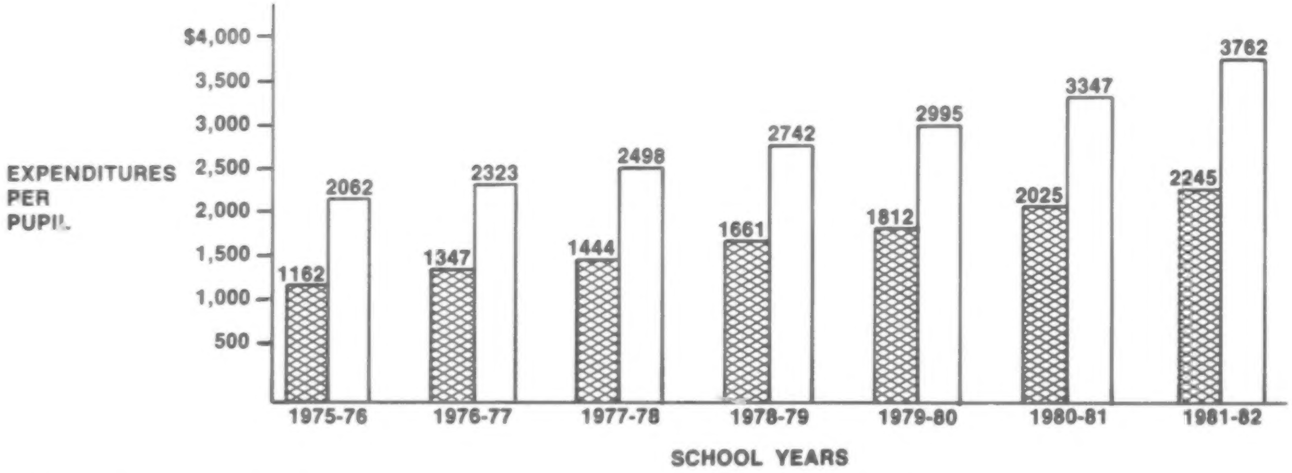
WIDESPREAD RECOGNITION OF INEQUITIES

There is widespread recognition of the impact of the inequities in funding for education as well as recognition of the need to revise the current funding formula. For example:

- Department of Education Commissioner Saul Cooperman stated that solving the problem will required a blue-ribbon panel to "overhaul" the state school funding formula.[10]
- The New Jersey School Boards Association's policy is "to work for a more equitable system of school finance."[11]
- Members of the Legislature have noted that there are still "vast differences" between rich and poor school districts,[12] and that the state must first fully fund education as it was ordered to do so in 1976.[13]
- The Governor's Management Improvement Team reported that "(t)he disparity between high-wealth and low-wealth school districts in spending levels and tax rates, which at first declined after the enactment of Chapter 212, appears to be moving toward pre-1975 levels."[14]

Graph: 3.5

SCHOOL EXPENDITURES PER PUPIL IN DISTRICTS WITH HIGH AND LOW LEVELS OF PROPERTY WEALTH IN NEW JERSEY
1975-1982



▨ **Low Property Wealth Districts (Districts at the 5th Percentile)**
The 25 school districts which spend the least amount per pupil (less than $2245 in 1982) and educate the 5 percent of New Jersey's children coming from the poorest districts.

☐ **High Property Wealth Districts (Districts at the 95th Percentile)**
The 50 school districts which spend the greatest amount per pupil (over $3762 in 1982) and educate the 5 percent of New Jersey's children coming from the wealthiest districts.

From: Margaret E. Goertz, *An Analysis of the New Jersey School Finance System,* Table 38 (prepared at the Educational Testing Services, May 1983, for the Education Law Center)

COMMITMENT AND TECHNICAL EXPERTISE NEEDED TO REVISE THE FORMULA

There is agreement that the funding formula should be changed, but little agreement as to how it should be done. In providing equity in the funding formula, there are complex, technical issues to consider which include:

- **Municipal overburden**

  The principal source of local school revenues is the local property tax. In 1981-82 the size of a school district's tax base was a primary factor in determining how much local revenue could be raised for education.[15] "Although the needs of the municipality are not educational ones, they compete for the same tax base. These pressures are greater for urban, generally poor areas rather than generally wealthy ones."[16]

- **Unique educational need**

  In New Jersey the districts with the highest level of educational need have fewer resources than the districts with the lowest level of need.[17] These students include children who achieve low basic skills scores, exhibit disruptive behavior, and/or drop out of school. Since educating pupils with high levels of educational need is expensive, this factor also needs consideration.

- **Variety of funding formulas**

  The education funding structure which includes different combinations of state, federal and local funds generated via various mechanisms compounds the already existing disparate situation between wealthy and poor districts. For example: the Special Services School Districts are 67.5 percent state, 17.5 percent county, and 15.0 percent locally funded while local school districts are funded on an excess cost categorical factor basis.[18] When the funding formula for Chapter 212 was devised in 1976, only funding to local school districts was considered.

The development of a new formula for financing public education in New Jersey is beyond the purview of this Committee. However, it is clear that the existing formula must be revised to assure that all children have an equal opportunity for adequate educational services. The technical expertise and commitment of individuals at all levels of government will be necessary to solve this serious problem confronting the children and taxpayers of New Jersey.

RECOMMENDED ACTION

A Blue-Ribbon Commission of qualified persons, including experts in education finance, process and citizen advocacy should be established to prepare recommendations to the Governor and the Legislature for revisions in the State's current system for financing public education.

The mandate of the Commission should be to develop revisions which would: eliminate the grave disparities among educational districts; assure that children in all school districts have equal opportunity for a thorough and efficient education as required by the State's Constitution; and assure equality of programs and services to populations with special needs regardless of the child's residence.

NOTES

1. *Robinson v. Cahill,* 62 NJ 473 (1973).
2. This challenge to the funding formula for public school education in New Jersey has been brought on behalf of urban students by the Education Law Center. The case was initially dismissed by the New Jersey Superior Court in 1983 for failure to exhaust administrative remedies. On appeal, the trial court decision was reversed and the case was reinstated for trial in 1984. Subsequently, the New Jersey Department of Education petitioned for Supreme Court review. Oral arguments were heard in November, 1984 and the case is now pending decision of the New Jersey Supreme Court. *Abbott v. Burke,* No. C 1893-80 (N.J. Super., order of dismissal, November 28, 1983); *rev'd* 195 N.J. Super. 59 (1984); No. 22,763 (argued November 11, 1984).
3. Margaret E. Goertz, *An Analysis of the New Jersey School Finance System* (prepared at the Educational Testing Service, May, 1983, for the Education Law Center).
4. *Ibid.*
5. *Ibid.*
6. *Ibid.*
8. *Ibid.*
9. *Ibid.*
10. Saul Cooperman (Commissioner, New Jersey Department of Education) as cited by Robert Schwaneberg, "School Chief Defends Urban Initiative Program," *Star Ledger,* 4 April 1984.
11. Paul Flohn, (Chairman, Urban Education Study Committee of the New Jersey School Boards Association), *Final Report of the Educational Needs of Urban Districts* (prepared for the Semi-Annual Delegate Assembly of the New Jersey School Boards Association, December, 1982).
12. Gerald Stockman (Senator) as cited by Robert Schwaneberg, "School Chief Defends Urban Initiative Program," *Star Ledger,* 4 April 1984.
13. Dean Gallo (Assemblyman) as cited by Frank Herrick, "Reform Bill Targets New Jersey Property Tax," *Trentonian,* 1 May 1984.
14. *Governor's Management Improvement Plan: State Aid to Elementary and Secondary Education* (Trenton, NJ: 1983).
15. Goertz, *An Analysis of the New Jersey School Finance System.*
16. Helen Lindsay, "T & E Revisited," *New Jersey Issues* (newsletter of the League of Women Voters of New Jersey, January, 1984).
17. Goertz, *An Analysis of the New Jersey School Finance System* and Paul Flohn, (Chairman, Urban Education Study Committee of the New Jersey School Boards Association), *Final Report of the Educational Needs of Urban Districts* (prepared for the Semi-Annual Delegate Assembly of the Association, December, 1982).
18. New Jersey Department of Education, Division of Finance, Trenton, New Jersey.

SCHOOL SUSPENSION PRACTICES AND POLICIES: REDUCING THE RATE OF SUSPENSIONS

New Jersey schools heavily rely upon suspension to discipline students, and, since 1977, more than 84,000 children have been suspended from school at least once in each school year. There are strong indications that suspension is often applied for very minor infractions and imposed arbitrarily when other, less drastic measures could be used to discipline a student. Further, there are wide variations among school districts in suspension practices, and the available data show that there is a disproportionately high rate of suspension for minority students.

- MORE THAN 84,000 SUSPENSIONS ANNUALLY
- SUSPENSION FOSTERS OTHER PROBLEMS
- INSUFFICIENT MONITORING OF SUSPENSION PRACTICES
- UNWARRANTED VARIATIONS
- ARBITRARY IMPOSITION FOR MINOR OFFENSES
- MINORITY CHILDREN MORE LIKELY TO BE SUSPENDED
- MINORITY DROP-OUT RATE RISING
- EFFECTIVE ALTERNATIVES EXIST

Princeton Packet, Rich Pipeling, Photographer

MORE THAN 84,000 SUSPENSIONS ANNUALLY

Since 1977, the number of New Jersey children suspended at least once from public schools has exceeded 84,000 each year. And, the available data strongly suggest that there has been increasing reliance on suspension. Despite the fact that the total number of secondary school students has declined by more than 14 percent, the overall rate of suspension has increased.[1] In 1981-82 alone, 87,000 children or 7.4 percent of all those enrolled, were suspended at least once.[2]

The problem of high rates of school suspensions is not a new one in New Jersey. In fact, a 1974 national study of school districts representing 50 percent of all public school enrollments in the country found that New Jersey with a 6.4 percent suspension rate had the sixth highest rate of suspension in the nation.[3]

SUSPENSION FOSTERS OTHER PROBLEMS: DENIES TROUBLED CHILDREN HELP, LABELS THEM TROUBLEMAKERS

There are compelling reasons to examine suspension practices in New Jersey. Suspension results in the removal of a child from her/his daily educational program, and interrupts the child's education. Suspensions also harm children, inter alia, in these ways: labeling children as troublemakers, thereby increasing the likelihood of repeated behavior problems; denying troubled children necessary help; and contributing to juvenile delinquency by putting unsupervised children with problems onto the streets.[4] According to one school administrator:

> Suspension serves no purpose at all only that it might worsen the problem. Put them on the street and let them go downtown and they'll begin doing the things that they wouldn't have done if they were in school. I don't even consider suspension because it does not help the kid. Where do the kids go when they are suspended? What do they do during the day .... they get a chance to get involved with people who are out there on the street .... fall prey to a lot of vicious kinds of things .... Why put them on the street?[5]

Further, short-term disciplinary exclusions often result in a significant loss of schooling which ultimately causes the youngster to drop out of school. In fact, a Children's Defense Fund survey found that almost 11 percent of youngsters who had dropped out of school cited suspension as the triggering device for their leaving school.[6]

And, in the long run, extensive use of suspension probably results in major costs to society. Because suspension may impair a youth's employability, it increases the risk that a youth will either become a burden to society or become involved in criminal activity.[7]

INSUFFICIENT MONITORING OF SUSPENSION PRACTICES

However, little is known about the full extent of suspension use in New Jersey. Records are not maintained at the state level on the total number of days individual youngsters are suspended.[8] Nor is data available to show how many times an individual student is suspended. Information from school personnel, parents and students alike suggest that back-to-back short-term suspensions are not uncommon and that many children experience multiple suspensions.

Monitoring of suspension practices is also impeded by the fact that almost no information is gathered to review how the schools apply suspension policies, what grounds the schools use to suspend a child and the lengths of suspension for specific infractions. Statements from school personnel, parents and students, however, strongly indicate that there are wide variations among school districts and even between schools in the same district in suspension practices.

UNWARRANTED VARIATIONS

National studies have documented that such patterns of wide and largely unwarranted variations in school suspension practices are common. For example: a 1978 National Institute of Education study found that "a student with a particular set of attitudes would be suspended in a school which suspends a large number of students and not suspended in a school which uses suspension less frequently."[9] The Children's Defense Fund study found that the "incidence of suspension is more a function of school policies and practices than the students' behaviors."[10]

ARBITRARY IMPOSITION FOR MINOR OFFENSES

Further, it has also been reported that suspensions are sometimes imposed arbitrarily when other less drastic measures could be used to discipline a student. Moreover, suspension is often used for very minor infractions even when excluding a child is not necessary to maintain order in the school.

Statewide data is not available on the extent of the problem, but the findings from one New Jersey suburban community illustrate the issue. As a result of widespread concern about the fact that 2,972 out-of-school suspensions amounting to 10,657 days of lost school time were imposed on secondary school students during the 1983-84 school year, a study of suspension practices was conducted by administrative staff in this school district. The study showed that the vast majority of the suspensions were for offenses such as tardiness, chewing gum and forgetting to bring gym shorts to school. Staff, board of education members and parents in this community are now working cooperatively to reduce the suspension rate.[11]

MINORITY CHILDREN MORE LIKELY TO BE SUSPENDED

Suspension data compiled by the New Jersey Department of Education strongly suggest that minority children are more likely to be adversely affected by these variations in practices. For example: although minority children represent only 27 percent of total enrollment, they account for 37 percent of the suspensions.[12] Further, an analysis done by the Department of the Public Advocate showed that in some counties a minority child was at least twice as likely as a white child to be suspended.[13]

Since extensive data on school suspension practices have not been reported, it is not possible to readily verify the reasons for the disproportionately high rate of suspension among minority children in New Jersey. However, national studies as well as informal reports suggest that in some instances minority children are treated differently and are subjected to discriminatory discipline practices.[14]

MINORITY DROP-OUT RATE RISING

Of concern as well is the fact that while the drop-out rates for white students are decreasing, they are rising for minority students. In 1978, when minority students comprised 26 percent of the total enrollment, minority students represented about 36.7 percent of all drop-outs.[15] By 1982, although minority student enrollment had increased by only 4 percent, the percentage of minority students in the drop-out rolls had climbed by 6 percent to 41.5 percent.[16]

Essex County's 1980-81 statistics[17] for suspension and drop-out provide an example of the extent to which differences can be found in the rates of suspension and drop-out when rates for white students are compared with those for minority students.

Similar patterns of higher rates for minority children are also evident in other areas of New Jersey.

LAW DOES NOT REQUIRE SCHOOLS TO USE LESS DRASTIC ALTERNATIVES

The reasons for variations in suspension practices are complex, but to some extent the variations are actually encouraged by New Jersey law. The law authorizing suspension and expulsion, N.J. STAT. ANN. 18A:37-2, is vague and permits local school districts substantial discretion in application. Further, the law does not require that schools utilize less drastic alternatives to resolve student discipline problems. The New Jersey Department of Education could require local school districts to follow specific guidelines in utilizing suspension, but has not set forth mandatory guidelines.

The attitudes **and** skills of school personnel also affect suspension practices. In some instances, negative reactions to students because of cultural, economic, physical, and personality factors play a major role in suspension decisions. Skills make a critical difference too, in how students are handled; lack of skills in identifying troubled students, defusing potential problem situations and responding to provocative behaviors contribute to higher suspension rates.[18] Further, according to a New Jersey educator, "(f)ailure to use sound instructional and learning practices that keep students engaged"[19] can also be a factor in suspension rates.

Princeton Packet, Rich Pipeling, Photographer

SUSPENSION OFTEN NEITHER NECESSARY NOR CONSTRUCTIVE

While on some occasions suspension may be the most appropriate method to address a serious discipline problem, often it is neither necessary nor constructive. National studies indicate that few suspensions are for violent behavior or physical aggression on school personnel. Most often students are suspended for "victimless" offenses such as smoking in school, truancy, and cutting class. Suspensions for fighting usually involve student on student altercations as opposed to attacks on school staff.[20]

EFFECTIVE ALTERNATIVES EXIST

There are a broad range of alternative programs and services which may be utilized to address student problems which might otherwise have resulted in suspension.[21] According to the New Jersey Department of Education, alternative programs have been effective in reducing the numbers of children suspended or expelled from school but sufficient programs to meet the need have not been developed.[22] Currently, the Department of Education is placing an emphasis on encouraging local school districts to develop alternatives to suspension.[23]

New Jersey schools which are interested in developing alternative programs can also draw upon the Education Information Resource Center for information on model programs as well as technical assistance in establishing the programs. One model program identified by the EIRC, Project COOL, was used in North Carolina for disruptive students with these results:

- Suspensions and expulsions at participating schools were reduced by 37 percent from the prior school year.
- The number of student referrals to the courts was reduced 50 percent.
- Truancy was reduced over 50 percent.
- The number of physical assaults on pupils and teachers was reduced by 41 percent.[24]

Project COOL was also effective in improving student-teacher relationships among the target population and the grades of most of the students improved.[25] These kinds of results strongly suggest that even disruptive students can be effectively handled without excluding them from school.

Where administrative policies disfavor use of suspension as an immediate method of dealing with discipline problems, the rate of suspension can drop dramatically even in troubled urban schools. One example is the experience of South Boston High School in Massachusetts. With the advent of a new administrator who had qualities and skills such as those outlined in the New Jersey Department of Education's

Table 3.3

Comparison of white and minority students in Essex County 1980-81 using statistics for enrolled, suspended and dropout students

	ENROLLED		SUSPENDED			DROPOUT		
	Number	Percent of Total Enrollment	Number	Percent of Total Suspended	Rate/100 of Total Suspended	Number	Percent of Total Dropout	Rate/100 of Total Dropout
White	52,966	38.7	3,051	32.8	5.7	720	28.7	1.3
Black	67,058	49.0	5,546	59.7	8.2	1,393	55.5	2.0
Hispanic	14,954	10.9	685	7.3	4.5	389	15.5	2.6

position paper on alternative education programs,[26] the number of suspensions plummeted from 1,660 in 1976 to 83 in 1982. Here, the commitment of the administrator to keeping children in school resulted in a 95 percent decrease in the number of suspensions.[27]

Although there are no easy solutions to the problem of student discipline, it is clear that is not necessary to rely heavily upon suspension to sanction students. While some promising initiatives have been mounted in New Jersey to reduce the use of suspension, the rates of suspension remain high. Further, there continue to be serious questions about the extent of variations in suspension practices which can be answered only by close monitoring.

RECOMMENDED ACTIONS

I. DEVELOP STATE GUIDELINES

The Department of Education must develop guidelines to establish a framework for planning, implementing, and, evaluating suspension and expulsion practices and programs which assure that each student is provided an educational program which effectively decreases the behavior(s) leading to the need for disciplinary action.

II. LOCAL POLICIES, PRACTICES, STAFF TRAINING AND ALTERNATIVE PROGRAMS

School Districts must develop and implement disciplinary practices and policies which assure:

A. That pupils being disciplined are being provided continuous education in compliance with Thorough and Efficient programs.

B. That there is a continuum of educational programs to address the needs of this population.

C. That the community is informed, involved and supportive of these programs.

D. That pupils are educated in a group setting as opposed to being isolated as in home instruction.

E. That school personnel are trained to:

1. Sensitize personnel as to how their own attitudes and values may result in differential treatment of students and provoke negative student reactions.
2. Increase personnel understanding of cultural and economic influences on students and their parents.
3. Show personnel how to identify troubled students early on.
4. Make personnel aware of practices likely to cause discipline problems.
5. Illustrate methods of promoting positive student behavior and motivation.

F. That a range of alternatives to suspension that meet Department of Education criteria are uniformly available and utilized such as:

1. The alternative programs suggested in the **Department's Alternative Education Programs for Disruptive Students.[28]**
2. Vocational education programs. These children should not be excluded from such programs.
3. The models developed by communities involved with the State Community Organization Project (SCOP) to address the needs of this population.
4. The alternative education programs developed by the New Jersey Department of Corrections.
5. Those programs in the resource guide created by the Interagency Youth Development Consortium and the Association for Children of New Jersey which can be adapted for use by the schools.[29]
6. The model programs available through the Education Information Resource Center which have proven effective in reducing suspensions and explusions.

III. STATE MONITORING OF LOCAL PRACTICES

The Department of Education (D. of Ed.) should monitor the disciplinary practices of the local school districts to assure that the Department's guidelines are followed and no district relies unnecessarily on suspension to sanction students. To this end, the D. of Ed. should formally monitor local school districts' suspension practices on an annual basis, and review the findings as part of the certification process. School districts which evidence excessive and unwarranted use of suspension should not be certified by the D. of Ed. until a plan for corrective action has been established by the school district. Further:

A. Local school districts should be required to maintain logs of all disciplinary actions that result in a child's suspension or expulsion from school. A running log should be developed to indicate the number of times and number of days each child is excluded from school. The log should specify: reason for the action; all that has been done previously to handle the problem with the student, including alternative methods of discipline; the nature and extent of the sanction; the policy which has been violated; and the age, sex and race of the student.

B. These logs should be forwarded monthly to the county superintendent who should report this information on a quarterly basis to the Commissioner of Education.

C. The county superintendent should monitor the due process aspects of the exclusion issue.

NOTE: See footnote 30 for Department of Education comments on the recommendations.

NOTES

1. See suspension data reported for 1977-78, 1978-79, 1979-80 and 1980-81 in New Jersey Department of Education, *Vital Educational Statistics* (Trenton, NJ: 1979, 1980, 1981, 1982).
2. Statistics for 1981-82 reported by the New Jersey Department of Education, Office of Management Information, September 30, 1983.
3. Marian Wright Edelman, *School Suspensions—Are They Helping Children?* (Cambridge, MA: Children's Defense Fund, 1975). The suspension rate data in this report was based upon analysis of information submitted by 2,862 school districts with a total of 24.2 million students to the federal Office for Civil Rights. The reporting districts were those who, because of substantial minority enrollments, might have been likely to have higher than average suspension rates. Although it might be expected that the rate of suspension reported for New Jersey might be higher than usual given the type of districts reporting, the 6.4 percent rate found was lower than New Jersey's overall rate for 1981-82.
4. *Ibid.*
5. Gwen Wilks, (Master Teacher, Everywhere School, Hartford, Connecticut), cited in Edelman, *School Suspensions.*
6. Edelman, *School Suspensions.*
7. Antoine M. Garibaldi, ed., *In-School Alternatives to Suspension: Conference Report* (Washington, DC: National Institute of Education, U.S. Department of Health, Education and Welfare, U.S. Government Printing Office, 1979).
8. New Jersey Department of Education, "Consolidated Enrollment Report: Drop-Out Information: Suspension and Expulsions" (Trenton, NJ: 1983), line D22.
9. *Violent Schools—Safe Schools, Safe Schools Study Report to the Congress,* Vol. I (Washington, DC: National Institute of Education, U.S. Department of Health, Education and Welfare, U.S. Government Printing Office, 1978).
10. Edelman, *School Suspensions.*
11. This information was obtained from a report distributed in August, 1984 by the school district at a special board of education meeting to address the community concerns regarding the suspension rate and practices. The report showed, in fact, that there were a total of 7,783 suspensions which included 4,811 in-school suspensions. Altogether, the number of suspensions was higher than the total number of pupils enrolled in the secondary schools of this district. School district staff, the board of education and parents are now exploring the feasibility of alternatives such as use of detention, special programs for chronic offenders and a pilot program for students with attendance related problems.
12. The enrollment statistics cited here for minority students include only Black and Hispanic students as reported in New Jersey Department of Education, *Vital Educational Statistics* (Trenton, NJ: 1983). Suspension data as well are only for Black and Hispanic students as reported by the New Jersey Department of Education, Office of Management Services, September 30, 1983.
13. Stephen Eisdorfer, (Assistant Deputy Public Advocate, New Jersey Department of the Public Advocate), testimony before the New Jersey Commission on Children's Services, September 21, 1981.
14. Children's Defense Fund, *Children Out of School in America* (Cambridge, MA: 1974); Edelman, *School Suspensions;* and C. Yorkievitz and M. Flynn, "Characteristics of Suspended Students," (unpublished report of the Project for Fair Administration of Student Discipline, University of Michigan School of Education, 1977).
15. New Jersey Department of Education, *Vital Educational Statistics* (Trenton, NJ: 1979).
16. New Jersey Department of Education, *Vital Educational Statistics* (Trenton, NJ: 1983).
17. New Jersey Department of Education, *Vital Educational Statistics* (Trenton, NJ: 1982).
18. Edelman, *School Suspensions,* and remarks of Richard Green, (West Area Superintendent of the Minneapolis public schools), *In-School Alternatives to Suspension: Conference Report.*
19. Harriet Doss Willis, (Director, Division of General Academic Education, New Jersey Department of Education), statement, May 11, 1984.
20. Edelman, *School Suspensions.* See also the findings of the Project for the Administration of Student Discipline reported by Junious Williams, "In-School Alternatives to Suspension: Why Bother?" *In-School Alternatives to Suspension: Conference Report.*
21. Alternatives to school suspension may include: Peer Group Counseling, In-School Centers, Work Study Alternatives, Special Education Programs and Alternative Schools. For a discussion of various alternatives, see Edelman, *School Suspensions,* chpt. 6.
22. Fred G. Burke (Commissioner of the New Jersey Department of Education), testimony before the New Jersey Commission on Children's Services, May 18, 1981.
23. New Jersey Department of Education, Division of General Academic Education, *Alternative Education Programs for Disruptive Students* (June, 1984).
24. Edwin L. West, Larry Allred and Paul P. Hounshell, "The COOL Connection: Alternative to Suspension," *Middle School Journal,* Vol. IX, No. IV (1978).
25. *Ibid.*
26. *Alternative Education Programs for Disruptive Students.*
27. Ellie McGrath, "Preparing to Wield the Rod," *Time Magazine,* Vol. 123, No. 4, January 23, 1984.
28. New Jersey Department of Education, Division of General Academic Education, *Alternative Education Programs for Disruptive Students* (June, 1984).
29. Interagency Youth Development Consortium and Association for Children of New Jersey, *Resources for Positive Youth Development* (Newark, NJ: 1984).
30. Harriet Doss Willis, (Director, Division of General Academic Education of the New Jersey Department of Education), advised that the Department has already taken steps to develop a Code of Conduct to be available in August, 1984. Ms. Doss Willis also commented that Recommendation 3 "is commendable. If districts are required to be 'self-conscious' about their suspension actions, they are more likely to address 'who' is frequently suspended, i.e., race, sex, etc.," statement, May 11, 1984.

UNDER-ENROLLMENT OF HISPANIC SCHOOL-AGE CHILDREN: ASSESSING THE PROBLEM

Available data suggest that there is a statewide problem of under-enrollment of Hispanic school-age children. The full extent of the problem and the reasons for the pattern of under-enrollment have not been assessed.

- DEPARTMENT OF EDUCATION FOUND REASON FOR CONCERN
- NATIONAL STUDY FOUND SERIOUS PROBLEM
- FULL EXTENT OF THE PROBLEM UNKNOWN
- SPECIAL OUTREACH EFFORT NEEDED
- ACTION POSSIBLE THROUGH HISPANIC ADVISORY GROUPS

New Jersey Department of Human Services

As noted elsewhere in this report, the Committee is gravely concerned about the increasing drop-out rate among minority students who, although they represent only 30 percent of total student enrollment in New Jersey, account for nearly 42 percent of all drop-outs.[1] Of special concern, however, is the fact that there are strong indications of a statewide problem of under-enrollment and unusually high drop-out rates among Hispanic school-age children.

DEPARTMENT OF EDUCATION FOUND REASON FOR CONCERN

This problem was first highlighted by the New Jersey Department of Education in its 1981 testimony before the Commission on Children's Services. The department, basing its findings upon work within the city of Newark, estimated that as many as 70-80 percent of the school-aged Hispanic youth were not enrolled in or attending city schools. The department further testified that the extent of the problem needed to be more thoroughly documented, and that strategies for correcting the problem should be developed and used throughout the state.[2]

Although a full assessment of the dimensions of the problem in New Jersey has not yet been conducted, the department did complete a preliminary review for the Governor's Committee. Based upon that review, the department concluded that "there is a valid concern regarding the drop-out rate among Hispanic children ages 15-19, which merits further study."[3]

NATIONAL STUDY FOUND SERIOUS PROBLEM

The findings from a recent national study focused on inner city schools show that the problems of under-enrollment and high drop-out rates among Hispanic children are a national pattern which may be related to the inability of the schools to meet the needs of Hispanic children. In fact, the 1984 report of the National Commission on Secondary Education for Hispanics indicates that there is strong evidence that many schools are failing to reach Hispanic children.[4]

According to the National Commission, a "straggering number" of Hispanic students drop-out or evidence low-achievement levels. The National Commission also found that "a shocking proportion of this generation of Hispanic young people is being wasted . . . because their educational needs are neither understood nor met."[5]

LEGISLATIVE ATTENTION

Both the New Jersey Legislature and the U.S. Congress have identified the need to assess the extent of the under-enrollment and drop-out problem among Hispanic students in New Jersey. During the 1983 Joint Appropriations Committee hearings of the New Jersey Legislature, several legislators focused in on this issue.[6] Further, members of the U.S. House of Representatives Select Committee on Children, Youth and Families also addressed the issue in the House Select Committee's 1983 hearings. In fact, information on the New Jersey patterns of under-enrollment was included in the House Select Committee's 1983 report.[7]

FULL EXTENT OF THE PROBLEM UNKNOWN

In the absence of a thorough review, it is impossible to ascertain whether the problem in New Jersey is limited to one of post-enrollment drop-out **or** whether substantial numbers of Hispanic children have **never** been enrolled in school at all on an on-going basis. Further, reports from community members and school personnel in New Jersey urban areas with large Hispanic populations indicate that the problem of under-enrollment is not limited to the 15-19 year old population.

SPECIALIZED SURVEYS NECESSARY

Specialized survey techniques are necessary to fully assess the extent of the problem in New Jersey, identify those school districts where rates of under-enrollment are high, and ascertain the reasons why these children are not enrolled in school.

Some focus for efforts in New Jersey may be provided by the extensive findings of the National Commission on Secondary Education for Hispanics which identified a multiplicity of factors contributing to the problem.[8] While primary responsibility for addressing the problem rests with the Department of Education, the effort will be more successful if it is done with the cooperation of Hispanic community-based programs and other local agencies which serve the Hispanic population. These agencies and programs can assist the department in identifying groups of unserved children as well as learning the reasons why some children are not in school.

SPECIAL OUTREACH EFFORT REQUIRED

It will also be necessary to implement a special outreach effort to encourage the enrollment of these children in school. In many instances, this would best be accomplished through existing community-based agencies in the Hispanic community.

ACTION POSSIBLE THROUGH HISPANIC ADVISORY GROUPS

Currently, there are two state-level advisory groups which could also work with the Department of Education in addressing the problem. In March, 1984 the Governor established the Advisory Committee on Hispanic Affairs by Executive Order 63 to address the special needs of New Jersey's Hispanics. Also, an Advisory Commission on Hispanic Affairs was established by law in 1984.[9] Both of these advisory bodies have representation from the Hispanic community and the ability to involve the community in resolving issues of particular import to Hispanics. The Advisory Commission in particular has the potential to address problems at the local level since it has the authority to work with county and municipal commissions on Hispanic affairs. The involvement of the members of both of these advisory groups in addressing the problem would help bring the expertise and leadership of the Hispanic community to the effort.

RECOMMENDED ACTION

The Department of Education should place priority on alleviating the problem of under-enrollment of Hispanic school-age children and take these steps to address the problem:

A. Conduct a comprehensive survey of the school-age and preschool populations to identify the actual extent of the problem and the underlying reasons for it. Survey measures should include welfare departments, WIC programs and day care centers as well as those agencies which specifically serve Hispanic families.

B. Develop an outreach program to identify Hispanic children who are not enrolled in school and to make provisions for their enrollment. The cooperation of Hispanic community-based agencies should be obtained for this effort.

C. Provide a representative of the Department of Education to consult with the Advisory Commission on Hispanic Affairs and/or the Advisory Committee on Hispanic Affairs regarding the efforts to address this problem.

NOTES

1. New Jersey Department of Education, *Vital Educational Statistics* (Trenton, NJ: 1983). See Suspension Practices and Policies section of this report for additional discussion of this issue.
2. Fred G. Burke, (Commissioner, New Jersey Department of Education), "Educational Programs and Services for Children and Youth in New Jersey," (Statement offered in testimony before the New Jersey Commission on Children's Services, May 18, 1981), p. 61.
3. Sylvia Roberts, New Jersey Department of Education, Division of Compensatory/Bilingual Education, letter, 1984.
4. National Commission on Secondary Education for Hispanics, *Make Something Happen*, Vol. I and II (New York: Hispanic Policy Development Project, Inc., 1984).
5. *Ibid.*, Vol. I, prefatory note.
6. Wynona Lipman (Senator), Richard Van Wagner and John Watson (Assemblyman) raised the problem with New Jersey Department of Education Commissioner Saul Cooperman, New Jersey Legislature's Joint Appropriations Committee, April 13, 1983.
7. U.S. Congress, House, Select Committee on Children, Youth and Families, *Children, Youth and Families: 1983, A Year-End Report*, 98th Cong., 2d sess. (Washington, DC: U.S. Government Printing Office, 1984), p. 39.
8. National Commission on Secondary Education for Hispanics, *Make Something Happen*.
9. N.J. STAT. ANN. 52:9W-1.

FUNDING FOR EDUCATION OF CHILDREN IN STATE FACILITIES

Sufficient funding is not provided to meet the educational needs of the 4,000 New Jersey children in 94 facilities under the jurisdiction of the state. Educational services for these children, many of whom have serious handicapping conditions, are deficient because the existing categorical aid factors are inappropriate to the student level of need.

- **EXISTING CATEGORICAL AID FACTORS ARE INAPPROPRIATE TO THE LEVEL OF STUDENT NEED**
- **ADEQUATE EDUCATIONAL SERVICES ARE NOT PROVIDED**
- **SUPPLEMENTAL RESOURCES ARE DECREASING**
- **PROPOSALS FOR INCREASED CATEGORICAL AID FACTORS**

New Jersey Arts Council

Currently, there are 4,000 children in 94 facilities[1] under the jurisdiction of the state for whom educational services are mandated by the State Facilities Education Act (SFEA).[2] While the intent of this 1979 law was to assure that these children received the same educational opportunities given children in the public schools, that has not occurred.

Under the SFEA, funds are provided for the education of children in institutions and day programs operated by or through contract to the Departments of Human Services (DHS) and Corrections (DOC). These state aid and district tuition funds are supplemented by federal Chapter I funds.

To allocate the state funds, the SFEA established different categorical aid factors for each type of facility so that the funding for each child varies as to the type of facility in which the child is placed. These categorical factors,* which were increased in 1983 by .16 to cover the cost of child study teams, are applied in this manner to calculate the funding:

> The state average net current expense budget (NCEB) per pupil is added to the sum of the categorical aid factor times the NCEB. Example for a child in a DOC facility in 1983 with a categorical aid factor of .43:
>
> $2,818 NCEB + (.43 x $2,818) = $4,029.74 per child

EXISTING CATEGORICAL AID FACTORS ARE INAPPROPRIATE TO THE LEVEL OF STUDENT NEED

Educational services for many of these children are deficient because the existing categorical aid factors are inappropriate to the student level of need. Sufficient funding is not provided to meet the educational needs of these children, most of whom have handicapping conditions and special educational needs.

In his June, 1983 annual report to the Legislature, Department of Education Commissioner Saul Cooperman listed a number of inequities in the funding of educational services for children:

> **Disparities between state facilities and local school districts in funding for special education services**
>
> - "Most students in correctional facilities are or would be eligible for categorical aid for the education of the handicapped in public school districts. The additional costs for providing special educational programs are not covered by the cost fac-

tors for correctional facilities . . ." Thus, although many of the children in these facilities have handicapping conditions, funds are not provided for special educational services for them.

- Although the categorical aid factor for emotionally disturbed children in the public schools is 1.27, it is only .16 for children in psychiatric hospitals. As a result, funds for the education of emotionally disturbed children in these state hospitals are substantially less than those provided for such children in public schools.

Disparities among state facilities

- Even though DOC programs are no less costly to operate than those in other state residential facilities, funds for children in DOC programs are based upon a .27 categorical aid factor as opposed to the 1.06 factor used for residential youth centers operated by DHS.
- The educational needs of and standards for children in residential facilities and day training centers for the retarded are the same. However, the categorical aid factor used for children in the residential facilities is only 1.26 v. 2.07 for those in day training centers.[3]

ADEQUATE EDUCATIONAL SERVICES ARE NOT PROVIDED

Since sufficient funding is not provided through use of the categorical aid formulas, adequate educational services cannot be provided for these children. For example: the 1983 categorical aid factor provides only 36 percent of the funds deemed necessary to achieve minimal compliance with current state regulations for the education of children under the care of DHS in psychiatric facilities. Further, information reported by DHS shows that the categorical aid provided for 1984 was not sufficient to meet minimal compliance levels for educational programs in any of the DHS facilities. To illustrate:[4]

Table 3.4

Percent of compliance level met in DHS programs under current funding levels and number of children affected

Type Facility	Percent Compliance Level Funded	# Children Affected
Div. of Mental Health and Hospitals (DMH&H)		
—adolescent programs	36%	
—post-adolescent	54%	194
Div. of Youth and Family Services (DYFS)		
—autistic	59%	20
—residential	69%	170
Div. of Mental Retardation (DMR)		
—residential	89%	752
—day programs	84%	979
—other day program	69%	264

Table 3.5

Categorical aid factors for the education funding of children in State Facilities: Actual FY '85 factor, approved FY '86 and recommended FY '86 factor

	Now*	Categorical Aid Factor Approved for FY '86	Recommended
Corrections	.43	.50	1.42
Human Services			
DMH&H	.32	.95	2.40
DYFS	1.22	1.33	2.58
Autistic (DYFS now)	1.22	1.33	3.09
DMR (Residential)	1.42	1.42	2.08
DMR (Day Programs)	2.23	2.37	3.20
DMR—Bureau of Special Residential Services (Day Programs now)	2.23	2.37	3.93

*Includes the .16 factor added to each category in FY '83 to cover the cost of a child study team.

COST

	Existing	Proposed**
DOC	$ 6,697,860	$11,334,840
DHS	18,352,746	25,585,998
	$25,050,606	$36,920,838

**Provides an increase of $11,870,232 or $2,937 more per child.

DHS for 2,379 children in 60 facilities
DOC for 1,662 children in 34 facilities
Total 4,041 children*** 94 facilities

***Count as of September 30, 1983.

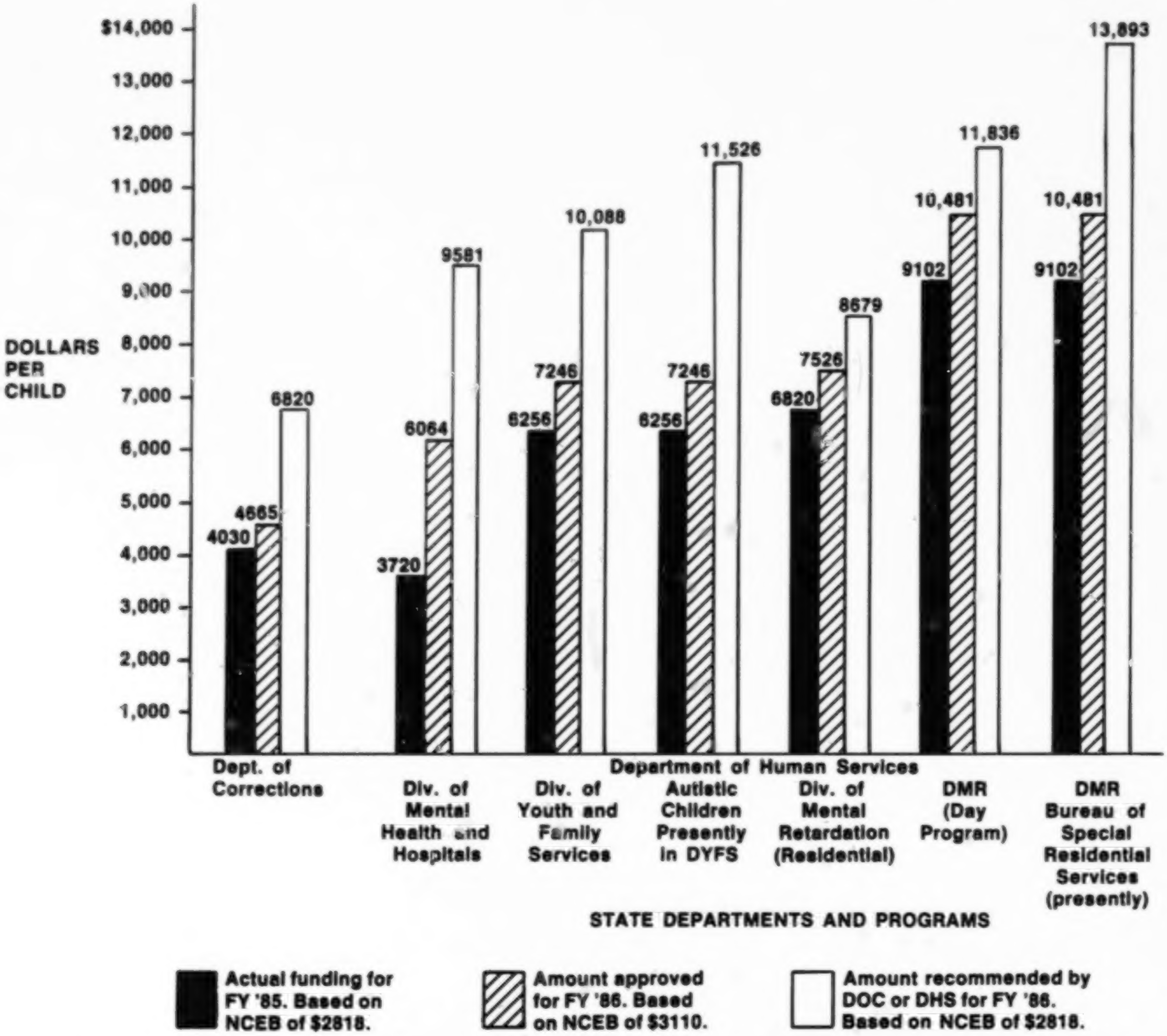
Moreover, the SFEA funding does not provide for administrative costs, staff in-service training and travel, student transportation, and substitutes which are all necessary for the success of educational programs in state facilities. In some instances, local school districts in which the facilities are located have had to absorb the costs of transportation of students who attend the schools, a situation which "unjustly burdens districts in which state facilities are located."[5]

SUPPLEMENTAL RESOURCES ARE DECREASING

In prior years, the departments have been permitted to use unexpended funds to supplement those initially provided through the SFEA categorical aid factors. Consequently, some of the funding deficiencies were able to be mitigated. However, neither department is currently in a position to free additional funds for these

Graph 3.6

FUNDING FOR THE EDUCATION OF CHILDREN IN STATE FACILITIES
ACTUAL FY '85 FUNDING, APPROVED '86 FUNDING AND RECOMMENDED FY '86, PER CHILD



Information computed from categorical aid data in: New Jersey Department of Corrections, **Recommendations for an Increase in the Level of Categorical Aid Generated Through Chapter 207, Laws of 1979** (Trenton, NJ: January 12, 1984) and New Jersey Department of Human Services, **Recommendations for an Increase in the Level of Categorical Aid Generated Through Chapter 207, Laws of 1979** (Trenton, NJ: January 12, 1984) educational programs.

Federal funding under Chapter I has also been a major source of supplemental funding for the programs. In fact, for the first three years of SFEA's implementation, federal funds covered 30 percent of the full costs of the DHS educational programs. However, in 1984 the federal funds for the DHS programs were cut by 40 percent, and further cuts are anticipated. Further, in 1984 federal funding for children in DOC day programs was withdrawn, and SFEA funds must now cover the total educational cost for the 110 children in these programs.

An especially vulnerable population are those severely and profoundly retarded New Jersey children who are in private, out-of-state facilities. Neither the states nor the private institutions in which these children have been placed can be assured of providing supplemental funding where SFEA funds are insufficient to cover the cost of their educational services.

PROPOSALS FOR INCREASED CATEGORICAL AID FACTORS

The Departments of Corrections[6] and Human Services[7] have analyzed the educational needs of the children in facilities under their jurisdiction and reported that the following increased categorical aid factors are necessary to fund adequate programs.

As noted above, increases in the categorical aid factors have been approved for implementation in FY 1986.[8] While these increases will improve the situation, they will not meet the needs identified by DHS and DOC as illustrated in Graph 3.6.

To assure that existing deficiencies are fully eliminated, additional increases are required. Such increases would be a significant step towards providing children in state facilities the same quality of educational services provided for children who attend local public schools.

RECOMMENDED ACTION

The state should provide categorical aid sufficient to meet the educational needs of children in state facilities and to assure that they are provided with the same quality of educational services given other children.

NOTES

1. New Jersey Department of Education, *Commissioner's Annual Report to the Legislature: Implementation of the State Facilities Education Act of 1979* (Trenton, NJ: June, 1983).
2. N.J. STAT. ANN. 18A:7B-1.
3. New Jersey Department of Education, *Commissioner's Annual Report* (1983), p. 28.
4. New Jersey Department of Human Services, *Recommendations for an Increase in the Level of Categorical Aid Generated Through Chapter 207, Laws of 1979* (Trenton, NJ: October, 1983).
5. New Jersey Department of Education, *Commissioner's Annual Report* (1983), p. 27.
6. New Jersey Department of Corrections, *Recommendations for an Increase in the Level of Categorical Aid Generated Through Chapter 207, Laws of 1979,* (Trenton, NJ: January 12, 1984).
7. New Jersey Department of Human Services, *Recommendations for an Increase in the Level of Categorical Aid Generated Through Chapter 207, Laws of 1979.*
8. Increases in the categorical aid factors were previously recommended by the Governor's Committee on Children's Services Planning in February, 1984. The increases reported here were approved in June, 1984.

EDUCATIONAL SERVICES FOR CHILDREN IN COUNTY RESIDENTIAL FACILITIES

State law does not currently mandate that educational programs be provided for the more than 14,000 children admitted annually to county residential facilities such as shelters and detention centers. Although many of these children stay in the facilities for 30 days or more, they often are not given adequate educational services or sent to their local schools to continue their education.

- EDUCATIONAL SERVICES NOT MANDATED
- ADEQUATE EDUCATIONAL SERVICES NOT PROVIDED
- ACUTE AND UNIQUE EDUCATIONAL NEEDS
- PENDING LEGISLATION TO SOLVE THE PROBLEM

New Jersey Department of Human Services

Each year, thousands of New Jersey's school-age children are placed temporarily in county operated detention centers, shelters for juveniles in crisis and shelters for abandoned and neglected children. Although many of these children stay in the facilities for 30 days or more, they often are not provided with adequate educational services or sent to their local schools to continue their education.

EDUCATIONAL SERVICES NOT MANDATED

State law does not currently mandate that educational programs be provided for children in these facilities.[1] Further, existing statutes do not clearly establish the responsibility of the local school districts, the county government and the state to fund and operate programs for these children.[2] Consequently, sufficient funding and resources have not been made available to establish adequate educational programs in all of these facilities.

ADEQUATE EDUCATIONAL SERVICES NOT PROVIDED

While some kind of services are provided in most of the facilities, the quality of educational programs varies widely from county to county. Some counties have funded in-house educational programs or have obtained resources from local schools. In other instances, children have been placed in the community's public school programs.[3] But, as both the Governor's Adult and Juvenile Justice Advisory Committee[4] and a special task force of the Association for Children of New Jersey reported, often only minimal services are offered the children.[5]

The available statistics strongly suggest that large numbers of these children may be deprived of adequate educational services for substantial periods of time. According to information reported by the New Jersey Legislature, there are approximately 700 children in average daily attendance in the various county facilities.[6] In 1982, a total of 14,138 children were admitted to shelters for juveniles in crisis or detention centers. Of the 4,402 children admitted to shelters, 553 or nearly 13 percent stayed for more than 31 days in the facilities.[7]

Children also stay for extensive periods of time in the county detention centers, and the average length of stay appears to be increasing. In 1982, detention center admissions totaled 9,736 children.[8] The average length of stay exceeded 20 days in eight counties and, in three of those counties, the average length of stay was more than 25 days.[9]

ACUTE AND UNIQUE EDUCATIONAL NEEDS

These children usually have greater than average educational needs, and can ill-afford to be denied adequate educational services. According to a special report prepared by members of the Association for Children of New Jersey Education Task Force:

> Children in these types of residential facilities have very acute educational needs. Most have a long history of failure and frustration in the public schools. They are commonly three to five years below grade level in basic academic skill areas. Most have been out of school, whether suspended, expelled or truant, for weeks or months prior to placement in a county facility. A significant fraction have specific learning disabilities that have gone undiscovered and unaddressed in the public schools.[10]

The unique needs of these children could be met through provision of educational services that are tailored to their individual needs. Further, if appropriate educational services which met the criteria for credit were provided, the hours these children spent in the classroom while residing in the facilities would not be lost school time for them.

Moreover, the educational experience itself, if provided in the least restrictive environment possible, could actually minimize the disruption in the child's life and help ease the child's transition from the facility to the community and the local school. This could be achieved, for example, by using the resources of the local schools to operate programs wherever feasible rather than setting up wholly separate educational programs within the facility itself. In some instances, it would even be possible to prevent any interruption in the child's educational program if arrangements were made to transport the child from the facility to her/his regular school program.

PENDING LEGISLATION TO SOLVE THE PROBLEM

Since 1979, there has been widespread recognition of the need to mandate by law that appropriate and adequate educational services be provided for all children placed in county residential facilities. In fact, draft legislation was developed in 1979 by a group of professionals and community members concerned about the gap in educational services for these children.[11]

Currently, there is legislation pending, S.1282, to establish such a mandate. This bill, prepared with extensive input from professional, child advocates and community members, would make the governing body of each county responsible for providing a free, appropriate educational program for each child residing in a county facility.[12] This bill would also require that an individualized educational plan be developed to meet the unique educational needs of each child. The county and state would equally share the costs for the actual programs and services, but the state would be responsible for paying 90 percent of the costs of transporting the children to educational programs. According to an estimate prepared by the Department of the Public Advocate, the full cost of implementing the provisions of S.1282 would be about $2.8 million per year.[13]

RECOMMENDED ACTION

MANDATE AND PROVIDE EDUCATIONAL PROGRAMS IN COUNTY FACILITIES

The state should mandate that appropriate educational programs and services be provided for all children residing in short-term county residential facilities including but not limited to detention centers, shelters for children placed by the Family Part of the Superior Court as a result of juvenile-family crises, and shelters for neglected and abandoned children. Further, the mandated programs and services should:

- **Be adapted to the unique educational needs** of the children.
- **Include an individualized written plan** for each child which meets the individual educational needs of the child.
- **Afford appropriate credit and certification** for the successful completion of particular courses or activities.
- Be **provided in the least restrictive environment** possible, using the services of educators and the facilities of public and private schools in the community of origin or the local community where appropriate and in accordance with state law.
- Be developed in accordance with regulations established by the New Jersey Department of Education with the cooperation of the Departments of Human Services and Corrections.

Pending legislation, S. 1282, would provide the necessary mandate for the implementation of these educational programs and services.

NOTES

1. New Jersey Senate Education Committee Statement to Senate No. 1282, May 14, 1984.
2. Education Task Force, Association for Children of New Jersey, "Explanatory Statement to Preliminary Draft Bill for Education of Children in County Facilities" (unpublished document, 1979). This Task Force was composed of citizens and professionals who reviewed existing laws and policies regarding education of children in state facilities.
3. *Ibid.*
4. Governor's Adult and Juvenile Justice Advisory Committee, *Standards and Goals for the New Jersey Criminal Justice System: Final Report* (Trenton, NJ: State Law Enforcement Planning Agency, 1977), p. 264.
5. Linda J. Wood and Joan Hammond Brame, *Children in Detention and Shelter Care: Surveying the System in New Jersey* (Newark, NJ: Association for Children of New Jersey, 1979), pp. 59-62.
6. New Jersey State Education Committee Statement to Senate No. 1282, May 14, 1984.
7. New Jersey Department of Human Services, Division of Youth and Family Services, Bureau of Licensing, *JINS*

and Children's Shelter Statistics for Calendar Year 1982 (Trenton, NJ: 1983).

8. New Jersey Department of Corrections, Juvenile Detention and Monitoring Unit, *Statistics on Juveniles in Detention Facilities—1982—A Report to the Directors of Juvenile Detention* (Trenton, NJ: 1983).
9. *Ibid.*
10. Education Task Force, Association for Children of New Jersey, "Explanatory Statement to Preliminary Draft Bill for Education of Children in County Facilities."
11. This draft legislation was prepared by the Education Task Force of the Association for Children of New Jersey.
12. S. 1282, State of New Jersey, introduced February 23, 1984.
13. New Jersey Senate Education Committee Statement to Senate No. 1282, May 14, 1984.

IV.

- STEPS TO IMPROVE THE SOCIAL SERVICES SYSTEM
- A PLAN FOR A COMPREHENSIVE EARLY CHILDHOOD DEVELOPMENT PROGRAM
- CHILD CARE SERVICES: MEETING THE GROWING NEED

Donna Pincavage

ACTIONS TO IMPROVE PREVENTIVE AND SUPPORTIVE SERVICES FOR CHILDREN AND FAMILIES

INTRODUCTION

Many families need assistance at some point in providing for the healthy development of children and supporting the well-being of the family as a whole. In response to this need, a broad range of services has been developed with public and private funding.

This chapter reports the Committee's recommendations for improvements in the organizational arrangements used to provide these services, and also reports recommendatons for additional services to address specific needs. Three sections are included:

- Steps to Unify the Social Services system and make services more accessible for children and families.
- A plan for a Comprehensive Early Childhood Development Program for disadvantaged children to assure that they receive the stimulation and preventive services necessary for healthy development.
- Actions to meet the growing need for Child Care services.

STEPS TO IMPROVE THE SOCIAL SERVICES SYSTEM

Numerous reports and studies over the past 16 years have noted that New Jersey's vast array of public and private resources for social services is not organized into a unified system of family-centered services. Further, the current organizational scheme fosters fragmentation and duplication of services, and accountability for individual clients is diminished. Moreover, sufficient community-based preventive services are not available, and appropriate services are not consistently provided for Black and Hispanic families.

- **NO UNIFIED SYSTEM OF FAMILY-CENTERED SERVICES**
- **RECENT EFFORTS TO IMPROVE SERVICES**
- **INSUFFICIENT FUNDING**
- **UNRESOLVED SYSTEMIC ISSUES**
- **NO SINGLE, NON-STIGMATIZING SERVICE CENTER FOR ALL FAMILIES**
- **COUNTY-WIDE INFORMATION AND REFERRAL SERVICE NOT PROVIDED**
- **PARALLEL SYSTEMS LEAD TO OVERLAP AND DUPLICATION OF EFFORT**
- **FEASIBLE ADDITIONAL STEPS TO UNIFY SERVICES**

Princeton Packet, Paul Savage, Photographer

Over the past two decades, a vast array of services for children and families have been developed in New Jersey by state and local agencies. At least 26 different state government units as well as thousands of public and private local agencies either fund or directly provide services for children and families.[1]

NO UNIFIED SYSTEM OF FAMILY-CENTERED SERVICES

However, numerous reports and studies over the past 16 years have noted that New Jersey's social services' resources have not been organized into a unified system of family-centered services. As the most recent study by the Commission on Children's Services found in 1982:

> The current service delivery system . . . does not have a focus for coordination of services at either the state or the local level. Neither broad policies nor administrative arrangements organize public and private programs into a unified system that effectively allocates existing resources . . . the current organizational scheme fosters fragmentation and duplication of services . . . Accountability for individual clients . . . is diminished. Some children never receive the services they need.[2]

The Commission also identified other deficiencies in the services system such as:

- Inadequate planning so that resources were not targeted to the populations most in need, and resources were not equitably allocated
- Few preventive or early intervention services for families, particularly those at high-risk
- Insufficient supportive, community-based programs for families and children
- Inadequate services for Black and Hispanic families, and use of staff and agencies who could not relate well to the families and properly identify their needs.[3]

RECENT EFFORTS TO IMPROVE SERVICES

Through the state's lead social services agency, the Department of Human Services (DHS), a number of initiatives have been mounted to address the problems identified by the Commission on Children's Services. Those initiatives include:

- The creation of Human Services Advisory Councils in all 21 counties to do comprehensive planning of services
- The establishment of a state Human Services Advisory Council to provide public input for DHS policies
- Increased efforts to unify services at the local level, utilizing the local district offices of the Division of Youth and Family Services (DYFS) as a locus for county coordination efforts. Additionally, "county representatives" and "county coordinators" have been placed at the county level to increase coordination among state units and between state and local agencies
- Increased emphasis on the development and funding of preventive services, primarily through the Division of Youth and Family Services, and expansion of community-based programs
- Recruitment of minority staff for all levels of management and direct services, as well as increased utilization of minority-oriented community-based agencies

Additionally, in conjunction with the implementation of the new Family Part of the Superior Court in all 21 counties, priority has been placed on improving services for families and children in crisis. Crisis intervention units, required to provide around the clock services for juvenile-family crises, have been established in all counties,[4] either housed within the court system or in community-based agencies such as mental health clinics. Further, as mandated by the Family Court Legislation,[5] planning groups have been established in every county to assess youth needs and develop plans for services (see The Juvenile Justice System and the Family Court section of this report for additional details).

INSUFFICIENT FUNDING

All of these efforts have spurred substantial activity at both the state and local levels to widen the channels of communication among services providers and cooperatively establish needed community-based services. However, sufficient funding has not been provided for major expansion of the preventive services to be provided through DYFS. For example, for FY 1985, DHS received only $1.6 million to expand preventive services. Nor have adequate funds been made available for the expansion of services for juveniles in crisis and in conflict with the law (see The Juvenile Justice System and the Family Court section of this report for full discussion of this issue).

UNRESOLVED SYSTEMIC ISSUES

Further, despite these progressive steps, a major systemic issue which may affect the efficiency of services remains largely unresolved: although overall responsibility for administering publicly supported social services is vested in DHS, two parallel services systems operate at the county level. One major system is that composed of DHS services administered largely through the local DYFS district offices in all 21 counties; the other system is that operated through the County Welfare agencies. Both of these two service "systems" have responsibility for meeting the social service needs of children and families. Additionally, it may be said that with the advent of the Family Court and its ancillary services network, yet a third parallel system is in the making in some of New Jersey's counties where the emphasis has been placed on housing the services within the court system.

The existence of parallel yet similar services systems has in part been fostered by traditional policy and funding patterns which made a rather sharp distinction between services for families and "child welfare" services. The roots of the distinction originated in the 1935 Social Security Act which made separate provisions for providing income support for children in their homes, and "child welfare" services for the care and protection of neglected children.

These two separate provisions were intended to distinguish between children who could live at home and those who required substitute, out-of-home care. Thus, two types of services, with different financing and patterns of federal-state relationships were created. From these original services distinctions, two separate categories have evolved in New Jersey as well as in many other states.

PRESENT STRUCTURE OF SERVICES

Through the original provisions for income support, the network of County Welfare Agencies (CWA) has developed. Over the years, the role of the CWAs has been expanded to incorporate the provision of medical and social services in addition to income support programs for financially needy families.

While the CWAs focus primarily on those families who are AFDC recipients, social services are available to past and potential AFDC recipients too. The inventory of services varies from county to county, but generally includes: crisis intervention, in-home protective services for children and adults, day care for children and adults, home management services (including training in child rearing and health care), homemakers, referrals for health care services and transportation. The CWAs also provide less tangible services such as case management, information and referral for services from other agencies, and community advocacy and outreach.

The Division of Youth and Family Services (DYFS), has, on the other hand, evolved from the classic "child welfare" services model. Its predecessor organizations concentrated primarily on those children who required out-of-home placement and only minimal emphasis was placed on working with the families of children.

Over the past 15 years, the role of this agency has been gradually shifting away from the "child welfare" orientation. In the wake of increased awareness and reporting of child abuse and neglect, the need to protect children by offering services to strengthen the family has been recognized. One illustration of this transition is the fact that in 1972 the name of the agency was changed from the Bureau of Children's Services to the Division of Youth and Family Services. Further, the transition has included a move away from reliance upon out-of-home placement for children from troubled families and an increased emphasis on the development of in-home services.[6]

Thus, from its starting point as a child-oriented placement agency, DYFS has expanded to become the primary state social services agency for troubled families. However, in recent years, fiscal constraints accompanied by steady increases in the number of reported cases of child abuse and neglect have necessitated that DYFS place priority on serving those families where the children are at risk of child abuse and neglect.

Generally, DYFS provides in-home services similar to those offered by the CWAs. It, however, has two additional roles:

1. Investigation of child abuse and neglect reports and institution of legal action to intervene where the child is at serious risk
2. Provision of foster care and residential services for children who cannot live in their homes

The services system developing in some counties as part of the "Family Court" system represents yet a third entity in the overall structure at the county level. Since the Family Court has been designed to handle most family-related matters that might be brought before a court, the Family Court may become involved in a wide range of cases where the family problems may include: child abuse and other forms of domestic violence; child-parent conflicts; substance abuse by either the parent or the child; severe family dysfunction; a wide range of mental health problems; and juvenile delinquency.[7]

Many of the families coming before the Family Court require social services and, according to the law, the counties are required to develop plans for the provision of services for those families who become involved with the Family Court. In keeping with DHS's overall responsibility for the provision of services, it has been mandated to review the county plans which are subject to DHS's approval.[8]

In some counties, the emphasis has been placed on utilizing the existing community agencies to provide services for those families and children who become known to the court. However, in other counties the Crisis Intervention units are themselves being developed to include professionals able to provide a mix of on-going services beyond the crisis stage. Further, in some counties actual service programs have been housed within the court system.

In addition to the CWAs, DYFS and the courts, there are a myriad of other local public and private agencies which provide a wide range of social, health care, mental health, and employment-related services for children and families. Local public schools and law enforcement agencies as well have extensive involvement with children and families in the community.[9]

NO SINGLE, NON-STIGMATIZING SERVICE CENTER FOR ALL FAMILIES

Many moderate and middle-income families, including those who can afford to pay a fee for the services they receive, have need at some point for social services. However, the current structure for services at the county level does not include a single, non-stigmatizing social service center where all families can readily obtain information about and access to services.

Instead, families must go to either the CWA, DYFS or the courts which may open them to the stigma traditionally associated with the types of problems dealt with by these different entities. To illustrate: because CWAs are commonly tied in the public eye to welfare, there can be considerable stigma attached to receiving any sort of services through a CWA. Stigma is often attached as well to DYFS's services since the agency's role has focused on child abuse and neglect. Public perceptions about court-related services also lead to stigma for client families.

COUNTY-WIDE INFORMATION AND REFERRAL SERVICE NOT PROVIDED

In addition to the CWAs and DYFS, many different county agencies do an admirable job of attempting to provide information and referral services for any citizen who may contact them to inquire about services. But, systematic county-wide information and referral services generally have not been developed in the counties so that all citizens can have ready access to information about programs to meet their needs. Thus, citizens often have to call a number of different agencies before they can receive the kind of information they need about available programs and services.

A county-wide information and referral system which includes an inventory of all programs and eligibility criteria, can greatly improve citizen access to services and enhance the potential for citizens to receive services in a timely manner. For example, Atlantic County has begun implementing such a system to handle emergency situations. Funded by a special grant from DHS, the system includes a consortium of state and local agenices who are sharing responsibility for operation of the service.[10]

PARALLEL SYSTEMS LEAD TO OVERLAP AND DUPLICATION OF EFFORT

The existence of separate yet parallel service systems at the county level can lead to overlap and duplication of responsibility as well as effort. In many instances, this results in wasted resources and lack of clear accountability for the provision of services to families.[11]

For example, DYFS and the CWAs have divided responsibility at the local level for the attainment of the same goal; both agencies are charged with the task of providing services to strengthen the family and to protect individuals from abuse and neglect. Both agencies offer similar services, and both have similar clients with similar problems. In fact, the majority of the clients served by each of these agencies are from families who suffer from the most stressful social and economic conditions such as poverty, unemployment, poor housing conditions, urban blight, and troubled family relationships.

Often both of these agencies may be involved with the same family at the same time. One agency may be serving one of the family members, while another agency is serving other members of the same family. Further, completely "shared" cases are not uncommon.

The potential overlap between the two agencies is rather pointedly illustrated by the fact that an estimated 50 percent of the 65,000 children in foster care come from families who were receiving services from the CWAs.[12] The percent of overlap between the DYFS and CWA caseloads varies from one county to another, but in the highly urbanized areas as many as 70 percent of the DYFS families are also clients of the CWA.[13]

Many of the families and children who are brought before the Family Court are involved too with DYFS and/or CWA.[14] Further, many either need or are receiving services from other local agencies as well. However, despite the potential opportunities for dual or even multiple responsibility among different agencies for the same family or child, there is no single entity at the local level which is held accountable for assessing the client's needs and assuring that all the necessary services are provided in a timely manner.[15]

Princeton Packet, Rich Pipeling, Photographer

FEASIBLE ADDITIONAL STEPS TO UNIFY SERVICES

Ideally, a single social service system integrating all primary services should be available to serve all families in every county, and to assure that there is clear accountability for service delivery. However, implementing such a comprehensive overhaul of the services system is not feasible at the present time.

PILOT PROJECT

However, there are steps that could be taken to build upon the current efforts to unify services. For example, a logical next step would be to establish one or more pilot projects in selected counties bringing the functions of DYFS and the CWA together and, further, utilizing the new entity as a base for bringing together other local services within a single services center.

Such a pilot office could be designed to: provide a non-stigmatizing means of access to services for all families; reduce random movement of client families among different agencies; and increase accountability for service delivery via consistent case management for client families. Issues which would need to be considered in designing a pilot office include:

- Criteria for selecting the pilot county
- Extent to which the state and the county would respectively bear responsibility for funding the project
- Issues related to the re-assignment of staff from the existing CWA and DYFS district office. This would require assuring equality in pay scales and benefits, as well as planning for training to prepare staff for their roles within the pilot office.

Initial implementation plans could be developed by a special committee established by DHS in conjunction with the state Human Services Advisory Council. For best results, this committee would need to include high level state and county staff, employee representatives, and members of relevant advocacy groups who have the expertise to identify major implemention issues.

A county Advisory Board would also be necessary to establish a comprehensive implementation plan in the pilot county once it has been selected. This Board could also provide on-going review of the project and as well make recommendations to the state and county regarding policies and funding. However, it would be necessary for state government to continue to: maintain responsibility for setting overall policies and goals for services; monitor the operation of the project; set accountability controls; provide technical assistance; and evaluate the effectiveness of the project.

Components which would be necessary for completeness of this pilot effort would include:

1) **An Information and Referral System** providing easy access, information and referral on a 24 hour basis for all residents
2) **Case Management Services** providing for thorough needs assessment for each client, referral to needed services, coordination of services where several different types of services are needed, and follow-up as well as advocacy to assure that the client receives the necessary services
3) **Protective Services** for children and adults, including investigation of referrals
4) **Adoption Services,** including selection of adoptive homes, and supervision of the adoptive placement until the adoption is finalized
5) **General Social Services** such as: counseling, transportation, employment-related services, housing related services, and legal services
6) **In-Home Services** such as: homemaker, home-delivered meals, "friendly visitor" for the homebound; and day care
7) **Substitute care** for children and adults, including out-of-home day care, day treatment programs, foster care, and residential care

OTHER STEPS: CO-LOCATION OF SERVICES AND MULTI-DISCIPLINARY TEAMS

There are also other steps that can be taken to unify services at the local level which could be effectively taken in many of New Jersey's communities. For example, co-location of different agencies at the same site can result in improved coordination of services. Reviews of this approach indicate that co-location increases the level and quality of communication among different agencies, thereby increasing the potential for cooperatively serving shared clients. In some New Jersey communities, services have been co-located right at the neighborhood level in "Community Schools," public schools which offer community services in addition to education for children and adults.

The use of multi-disciplinary teams which bring together various professionals from different agencies to do joint evaluation and service planning for individual children and families is a second method to unify services. In one New Jersey community, DYFS staff in cooperation with the local school social worker and staff from the mental health clinic developed an on-going team which includes professionals from local as well as county and state agencies. In addition to fostering improved coordination of services for individual clients, the operation of the team has:

- Heightened the community's sense of responsibility for its families
- Increased the awareness of local agencies as to how community resources may be used to help families
- Fostered linkages among municipal, county and state agencies[16]

Further, in three New Jersey counties, Youth Services Commissions composed of service providers and community members have proven effective in building cooperative efforts among different agencies to plan and deliver services for youth.[17] Established in 1982, the Commissions have been instrumental in identifying unmet youth needs and the joint development of several new programs for youth (see The Juvenile Justice System and the Family Court section of this report for additional discussion).

The many recent initiatives by DHS in cooperation with other public and private services such as the steps discussed here. However, it should be noted, that no social services system can be truly effective when the recipients are families who are economically and socially deprived due to inadequate basic income supports, health care, housing and education. These basic, concrete needs must be provided for as part of the overall plan of services.

RECOMMENDED ACTIONS

I. CONTINUE AND EXPAND EFFORTS TO UNIFY SERVICES

The Department of Human Services (DHS) should continue and expand its efforts to unify services at the county level. Further, DHS should take these additional steps:

A. PILOT PROGRAM

Initiate a pilot program in one or more counties to test the efficiency and effectiveness of combining the services now administered by the County Welfare Agencies and DYFS into a single system for individuals, families and children which:

- Uses a "family welfare" approach placing priority on strengthening families
- Provides developmental resources defined by the community as appropriate for all children and families, not only the "poorest," the "sick," or the "maladjusted"
- Provides early intervention for abuse and neglect
- Provides services to enhance early childhood development

B. CO-LOCATION AND MULTI-DISCIPLINARY TEAMS

Place increased emphasis on developing:

- Co-location projects which bring different agencies to work together at the same physical location, so that the agencies are jointly housed
- Multi-disciplinary teams of professionals from different agencies to jointly evaluate the needs of individual clients and to plan services for them

II. FUNDING FOR PREVENTIVE SERVICES

The state should provide sufficient funding for DHS to fully implement its plan for the development of additional preventive and community-based services.

III. IMPROVE SERVICES FOR BLACK AND HISPANIC CHILDREN AND FAMILIES

DHS should continue its efforts to make the department's various services more relevant to the needs of Black and Hispanic children and families through steps such as: increasing the percentage of Black and Hispanic staff members at all levels of management and in direct services, and continuing the current priority on utilization of those community-agencies which demonstrate the capacity to provide culturally sensitive services.

NOTES

1. The New Jersey Commission on Children's Services completed an inventory of the services system as well as a review of the organization of services. For details, see: R. Alexandra Larson and Carol Kasabach, *Linking Policy with Need* (Trenton, NJ: New Jersey Commission on Children's Services, 1982), chpts. III-V.
2. *Ibid.*, pp. 7-8.
3. *Ibid.*
4. N.J. STAT. ANN. 2A:4A-76.
5. *Ibid.*
6. As part of this transition, there has been a marked decrease in the number of children in foster care, For example, from 1975 to 1982, the DYFS foster care caseload decreased by 30 percent to about 6,500 children. New Jersey Department of Human Services, Division of Youth and Family Services, *Foster Care and Adoption: A Commitment to Change* (Trenton, NJ: 1983), p. 2. This decrease is particularly significant in view of the fact that during the same period of time, there were dramatic increases in the numbers of reported cases of child abuse and neglect requiring DYFS intervention.
7. N.J. STAT. ANN. 2A:4-3a to -3e.
8. N.J. STAT. ANN. 2A:4A-76.
9. Larson and Kasabach, *Linking Policy with Need*, chpt. IV.
10. Coordinated Emergency Response System, tentative start-up date January 1, 1985.
11. Larson and Kasabach, *Linking Policy with Need*, chpt. IV.
12. Information based upon 1984 caseload provided by New Jersey Department of Human Services, Division of Youth and Family Services.
13. *Ibid.*
14. A formal study has not been done to assess the full extent of the overlap, but local level staff advise that at least half of the cases brought before the court are known to either DYFS or CWA.
15. Larson and Kasabach, *Linking Policy with Need*, chpt. IV.
16. This team has been in operation for more than a year in Spotswood, New Jersey. Information on the team was provided by Donna Pincavage, (District Office Supervisor, DYFS South County (Middlesex) Office); Bruce Yellin, (DYFS Social Worker, South County (Middlesex) Office); and Sarah Gordaychik, (Social Worker, Spotswood School District), in a meeting with representatives of the Governor's Committee on October 31, 1983. Additional information on the formation and operation of the team was obtained from Bruce Yellin, *Community-Based Multi-Disciplinary Teamwork—A Bottom-Up Perspective on the Integration of Social Service Delivery Systems* (unpublished paper dated April, 1984.)
17. Youth Services Commissions were established in Burlington, Middlesex and Somerset counties in 1982 as part of a special pilot project funded by the State Law Enforcement Planning Agency. Information on the achievements of the county Youth Services Commissions was obtained from the reports made to the state Youth Services Commission during 1982, 1983, and 1984.

A PLAN FOR A COMPREHENSIVE EARLY CHILDHOOD DEVELOPMENT PROGRAM

Thousands of New Jersey children from disadvantaged families suffer from a broad range of medical, nutritional, intellectual and emotional deprivations. As a result, these children are likely to experience permanent developmental disabilities which require costly remedial services and impair their ability to become productive members of society.

- IMPOVERISHED CHILDREN DEPRIVED OF DEVELOPMENTAL SUPPORTS
- PRESCHOOL PROGRAMS ARE HIGHLY COST-EFFECTIVE
- MANY NON-POOR CHILDREN ATTEND PRESCHOOL PROGRAMS
- EFFICIENT MECHANISM FOR PROVISION OF PREVENTIVE SERVICES
- PROMISING METHOD TO REDUCE THE RISKS TO CHILDREN OF ADOLESCENT MOTHERS
- A MEANS TO PROVIDE QUALITY CHILD CARE SO MOTHERS CAN WORK
- STEPS TO IMPLEMENT A STATE-SPONSORED PROGRAM

UMDNJ, Dan Katz, Photographer

Governor Thomas H. Kean, in Executive Order 35, set forth his strong conviction that "New Jersey's children shall be afforded the opportunity to develop to their fullest potential." In its efforts to identify measures to achieve this goal, the Governor's Committee has found that thousands of economically disadvantaged children in New Jersey are suffering from lack of the basic essentials for healthy growth and development such as:

- Proper nurturing and care
- Complete health care and nutrition
- Early intellectual stimulation and education to overcome environmentally related deficits
- The development of a positive identity
- A full range of therapeutic and rehabilitative services when required

Currently, there are at least 45,000 children in New Jersey between the ages of 3-5 years whose families have incomes below the federal poverty guidelines.[1] In recognition of the special needs of these children, federal funding has been provided since 1965 for comprehensive developmental services offered through the Head Start program. However, in New Jersey funding is available to serve only 9,000 or 20 percent of all the children who are income eligible for these services.[2]

IMPOVERISHED CHILDREN DEPRIVED OF DEVELOPMENTAL SUPPORTS

Many of these Head Start eligible children live in poverty-depressed urban slums, and in segregated, overcrowded and often unsafe housing. They are routinely exposed to the kinds of social pathology associated with urban blight. Their parents are often poorly educated, unemployed or underemployed, and afflicted with the severe stresses associated with living in poverty. Further, many of these children live in female-headed households and/or in large families where meager resources must be shared with many others.

Children reared in such circumstances are vulnerable to a broad spectrum of medical, nutritional and emotional deprivations. Further, their surroundings offer them few positive social, cultural or educational opportunities to move beyond their present circumstances.

These are children who can be said to be "programmed for failure," and subject to what has been termed "developmental attrition"—many of these children show a decline in developmental functioning prior to entering school when compared with more advantaged children. As a result of deficits commonly associated with poverty, the psychological and physical health of some of these children does not develop to its potential.[3]

STATE RESPONSIBILITY

The state, in its compact with the next generation, has the responsibility to assure that these children receive the services *and* developmental experiences required for normal and healthy development. Comprehensive, early childhood development programs, which offer health care, nutrition, intellectual stimulation, social services for the family, mental health services and rehabilitative services for specific problems, present a highly effective method of meeting that responsibility. This approach, which is utilized by the Head Start program, uses a center-based, multi-disciplinary model to help economically deprived families rear their own children and prevent or counteract the disadvantages associated with extreme poverty and discrimination.[4]

Currently, the state, through a blend of state and federal funding, provides support for day care center programs which primarily serve preschool age children. These programs are utilized essentially to provide care for the children of working parents, who pay a fee for the service which is based upon a sliding scale according to family income. Additionally, the day care centers also provide care at no cost for children who are at risk of abuse or neglect because of familial problems.

While these day care center programs can be beneficial to disadvantaged children, they are not a substitute for a program which specifically focuses on providing the full range of high quality developmental services. The Head Start model, which provides such services, makes them available to any age eligible child whose family's income is below the federal poverty guidelines.[5]

PRESCHOOL PROGRAMS ARE HIGHLY COST-EFFECTIVE

Numerous studies have shown that high-quality preschool programs have achieved significant positive goals both for society and programs participants. One recent report, *Changed Lives,* particularly demonstrates the cost-effectiveness of early childhood development programs.[6]

This landmark study followed the lives of 123 children from 1962 to 1982. These children were those with the odds against them—all were from poor families and Black in a society where discrimination was common.

To conduct the study, children with recorded I.Q.s from 60 to 90 were selected and then randomly divided into an experimental group and a control group. Less than one in five of the parents had completed school,

New Jersey Department of Human Services

and 47 percent of the children were from single parent families.

The children in the experimental group were provided with a half-day, high quality preschool education program on a daily basis for 7.5 months a year between ages 3 to 5 years. The children in the control group did not receive comparable preschool education services.

The progress of the children was then followed longitudinally, and the two groups of children were compared at age 8, again at age 15, and still again at age 19. The findings, some of which are illustrated in Graph 4.1, showed remarkable differences between the children who had been involved in the preschool education program and those that did not have this advantage. In fact, the preschool group showed substantially higher employment rates, and, for the girls, nearly 50 percent less teenage pregnancies.

Further:

- **67 percent of the preschool group graduated from high school as contrasted with 49 percent of the control group**
- **38 percent went on to some form of post-high school study, as compared with 21 percent for the control group**
- **20 percent fewer of the preschool group had dropped out of school**
- **preschool children were involved in 20 percent fewer arrests and detention than the control group children**
- **preschool children spent half as many years in special education**[7]

In contrast, there were twice as many arrests for deliquency among the control group children and almost twice as many dropped out of school. Further, over 50 percent were unable to fully support themselves through their own earnings. The study also found that **for every $1,000 invested in the preschool children, at least $4,130 (after allowance for inflation) had been or was expected to be returned to society** in the form of:

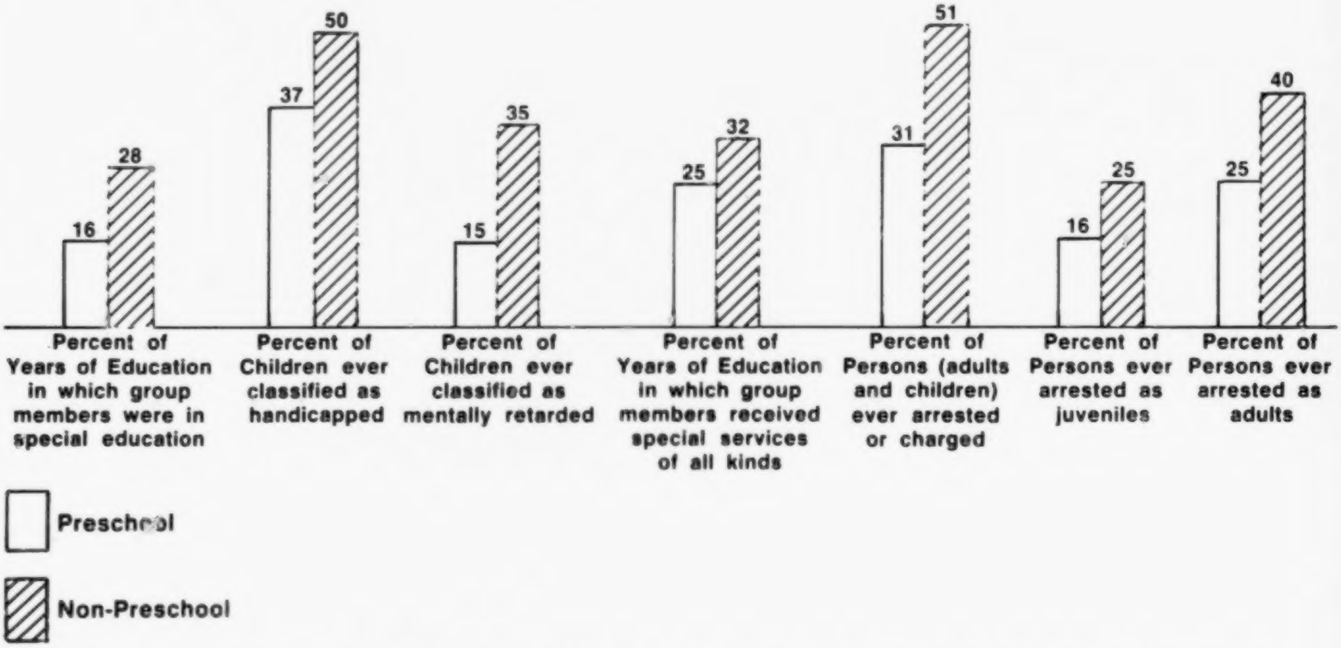
- **reduced costs for education**—the average costs of educating the preschool group through high school were nearly 20 percent or $7,000 less than for the control group **because preschool graduates required less remedial education**
- **reduced expenses for legal and other costs associated with crime**—$3,100 per child[8]

MANY NON-POOR CHILDREN ATTEND PRESCHOOL PROGRAMS

Preschool education has been expanding rapidly, but the children of educated and affluent parents are far more likely than impoverished children to attend a preschool program. As two Columbia University School of Social Work professors have pointed out, the value of preschool education is already known to the educated and affluent who make extensive use of this service for their children.[9]

Graph 4.1

CHILDREN WITH PRESCHOOL TRAINING VERSUS CHILDREN WITHOUT PRESCHOOL TRAINING: THEIR INVOLVEMENT WITH SPECIAL EDUCATION AND JUSTICE SYSTEMS



Source: John R. Berrueta-Clement, Lawrence J. Schweinhart, W. Steven Barnett, Ann S. Epstein and David P. Weikart, **Changed Lives** (Ypsilanti, MI: The High Scope Press, 1984) pp. 26, 64 and 65.

In fact, research has shown that "as parental income and education go up, so does the enrollment rate of their preschool children"[10] To illustrate: based upon 1982 data, the preschool enrollment rate for three and four year olds from families with incomes of $25,000 and above was 53 percent, while the rate of children from families with incomes below $25,000 was only 29 percent. Further, the children of educated mothers showed high rates of enrollment which were not closely related to the working status of the mother: where the mother was a college graduate, 50 percent of the three year olds and 72 percent of the four year olds attended preschool.[11]

EFFICIENT MECHANISM FOR PROVISION OF PREVENTIVE SERVICES FOR VULNERABLE CHILDREN

A well-designed early childhood development program can serve as a highly efficient mechanism for coordinating a broad range of preventive services for vulnerable children. As discussed elsewhere in this report, many of the state's disadvantaged children do not have ready access or access at all to the medical services and developmental supports that are critical for healthy development; in fact, the needs of these children are often almost completely overlooked. A community-based program focused on the child's developmental needs could be highly instrumental in seeing that the critical needs of individual children are promptly identified. Further, such a program could coordinate the provision of services for individual children, and see that the children and their families were linked with other appropriate community agencies for services.

PROMISING METHOD TO REDUCE THE PRONOUNCED RISKS OF ABUSE, NEGLECT AND DISABILITY TO CHILDREN OF ADOLESCENT MOTHERS

Additionally, a state-sponsored early childhood development program can provide a highly effective means of reducing the risk of child abuse, neglect and long term disabilities among children of adolescent mothers. In 1982 alone, over 11,000 children were born in New Jersey to mothers between the ages of 10-19 years;[12] the vast majority of these babies were born to unmarried girls, many of whom were ill-prepared for motherhood, and without sufficient financial or emotional support to meet their babies needs.[13] These children are particularly at risk of abuse and neglect because of the stresses upon their mothers due to lack of parenting skills, lack of supports and the dual status of being both an adolescent and a parent. Also, the children of adolescent mothers tend to be more vulnerable to health problems which makes their care more demanding and particularly stressful for inexperienced, unsupported young mothers.[14]

Few specialized services currently exist for this population of teenage parents and children, and many of these families become trapped into dependence on AFDC because the young mothers leave school prematurely.[15] Through an early childhood development program focused on needs of both the child and the family, these young mothers can develop parenting skills.

A MEANS TO PROVIDE QUALITY CHILD CARE SO THAT MOTHERS CAN ATTEND SCHOOL, JOB TRAINING OR WORK

Further, an early childhood development program which provides quality child care for young children can also have an added benefit: it can free mothers of young children to return to school or to seek job training or employment. The mix of services provided by a comprehensive program may be particularly crucial for teenage mothers who need both support in developing parenting skills as well as a safe, nurturing environment for their children if these young mothers are to return to school or obtain training.

For impoverished adults as well, child care services are critically needed to enable them to take steps to extricate their families from poverty. Currently, about 55,000 mothers in the families receiving AFDC have children under the age of six years, and about half of these children are between three to six years of age.[16] These and other impoverished mothers of young children are often locked into poverty because the unavailability of child care services constrains them from seeking training or employment. As pointed out in the following section of this report, there are tremendous gaps in child care services in New Jersey; services are particularly inaccessible for poor families who cannot afford to pay for private child care.

Lou Krefski, Photographer

STEPS TO IMPLEMENT A STATE-SPONSORED PROGRAM

In New Jersey, the availability of preschool education for disadvantaged children could readily be expanded through the establishment of a state-sponsored early childhood development program modeled after the Head Start program. Such a program, utilizing income and age as the only eligibility criteria, could be administered by the Department of Human Services which now has overall responsibility for the provision of a wide range of social and medical services for these children and their families. Further, an Interdepartmental Planning Council could be established to bring together experts from the Departments of Human Services, Health and Education to plan, implement and monitor the program.

Based upon an estimated cost of $3,000[17] per year per child with 80 percent of the costs funded by the state, the state would be required to spend $12 million to provide the program for one year to 5,000 children. Following the first year of implementation, the number of children served could be annually increased.

While at first glance, the costs of an early childhood development program may appear high, the costs will be more than off-set by the long-range savings for remedial education, health care problems, developmental disabilities, dependency and crime. Further, such a program can yield substantial additional benefits to children, families and society by reducing the risk of child abuse and neglect and providing child care for parents while they seek job training or employment.

RECOMMENDED ACTION

ESTABLISH STATE COMPREHENSIVE EARLY CHILDHOOD DEVELOPMENT PROGRAM

To meet the Governor's mandate that "New Jersey's children should be afforded the opportunity to develop to their fullest potential," the state should establish a Comprehensive Early Childhood Development Program for children ages three to five who live in families whose incomes fall below the federal poverty guideline.

A. PROGRAM ADMINISTRATION, PLANNING AND MONITORING

The Comprehensive Early Childhood Development Program should be administered by the Department of Human Services and should be planned, implemented and monitored by an Inter-Departmental Council composed of experts from the Departments of Human Services, Health and Education in accordance with the attached guidelines.

B. FIVE-YEAR IMPLEMENTATION PLAN

The program should be fully implemented over a five-year period. In the first program year, the state should serve 5,000 children. In each successive year, the number of children served should be incrementally increased until all eligible children are afforded the opportunity to participate in the program.

UMDNJ, Dan Katz, Photographer

RECOMMENDED GUIDELINES FOR AN EARLY CHILDHOOD DEVELOPMENT PROGRAM

I. PROGRAM PURPOSE

To create a Comprehensive Early Child Development Program for Economically Disadvantaged children in order to:

- Afford them the opportunity for healthy growth and development.
- Decrease the number of children presently eligible for, yet unserved by Title XX day care, as well as the Federal Head Start program.
- Build on the experience and knowledge gained through Federal Head Start and similar efforts.
- Assure that priority be given to:
  - a. Local areas of greatest need; and
  - b. Children with greatest economic and social need.

II. ELIGIBILITY CRITERIA

- Children, aged three to five years.
- Children from families with annual incomes below the Federal poverty level guidelines.
- Not less than 90% economically disadvantaged—below federal proverty guidelines.
- Up to 10% children with handicapped conditions.

III. FINANCING

- Eighty percent state funding.
- Twenty percent from Sponsoring Agency match. Sponsoring agency may meet its 20% match by in-kind contributions. Parents or guardians may participate in providing in-kind contributions.

IV. ADMINISTRATION

The Department of Human Services shall serve as the administering agency.

An interdepartmental Planning Council, comprised of professionals from the Departments of Human Services, Education, and Health, should be responsible for overall planning, development of their respective program guidelines and context, and preparation standards shall be undertaken by the Planning Council no less frequently than once every three yeas, and results reported to the Departments of Human Services, Education, and Health.

Agencies shall be required to perform self-assessments annually in accordance with State performance standards.

V. SPONSORING AGENCIES

The program will be implemented by sponsoring agencies or groups in the targeted areas who can demonstrate:

- The capacity to conduct or make available existing community assessment of need for the program.
- The capacity to operate the program in accordance with the goals and requirements established under state law, and with the standards and policies set by the Interdepartmental Planning Council.

VI. PRIME SPONSORS MAY BE:

- State, county, city or town agencies or units of government including school districts and County Advisory Councils.
- Nonprofit child care organizations or other voluntary organizations or groups.

VII. GRANT APPLICATIONS MUST INCLUDE A COMPREHENSIVE CHILD DEVELOPMENT PLAN SPECIFYING:

- Justification of need of service.
- Number of children to be served.
- Length of day (either half or one full day).
- Methods of implementing the goal.
- Budget required.
- Transportation plans, if provided.
- Eligibility requirements and priorities.
- Any additional data required in the Interdepartmental Planning Council guidelines.

VIII. LICENSING

The responsibility for licensing will rest with DYFS in accordance with present state requirements for publicly supported day care.

Any requirements which exceed the minimum DYFS standards for child care licensing as felt to be necessary by the Planning Council will become the standard for this program.

IX. POLICY COUNCIL

Each prime sponsor must have a Child Developmental Policy Council of not less than 12 members and not more than 16, including:

- One-fourth representatives of the community served.
- One-fourth professionals in child development.
- One-half parents of the children served.

X. PARENT INVOLVEMENT

Parents may be involved as:

- Volunteers in classroom or center.
- Paid employees as long as they meet prescribed standards.
- Decision makers on parent committee or agency board.

XI. PROGRAM COMPONENTS

A. Education:

1. To enhance social competence, intellectual stimulation, and the physical and emotional development of the child.
2. To involve parents in parent effectiveness training to enhance their role as the principal influence in the child's development.

B. Health:

Every child should have a physical examination before acceptance. The program must provide:

1. Medical, dental, mental health and nutritional screening and follow-up services. Screening services should include: Height, weight, vision, hearing, hematocrit and lead poisoning.
2. Monitoring should include (1) immunization status and follow-up, (2) family link with on-going health care services, and (3) treatment of all health problems detected.

C. Health education for children and parents.

D. Nutrition:

1. Provide at least one-third daily nutrition requirement.
2. Provide nutrition information.
3. Provide consultation service to parents regarding nutrition.

E. Social Services:
   1. Outreach and recruitment of children.
   2. Active parent participation in program activities.
   3. Educate parents to community resources and facilitate their use.
   4. Advocate for needed services.
   5. Assist family in its efforts to improve quality of life.

NOTES

1. This is an estimate based upon the U.S. Census, 1980.
2. For Fiscal Year 1983, the federal government provided $26.2 million to 34 New Jersey Head Start programs to serve an estimated 9,000 children. U.S. Department of Health and Human Services, Office of Human Development Services, Administration for Children, Youth and Families, "Project Head Start Statistical Fact Sheet" (April, 1983).
3. Julius B. Richmond and Milton Kotelchuck, Division of Health Policy Research and Education, Harvard University, "Commentary on *Changed Lives,*" John R. Berrueta-Clement, Lawrence J. Schweinhart, W. Steven Barnett, Ann S. Epstein and David P. Weikart, *Changed Lives* (Ypsilanti, MI: The High/Scope Press, 1984), p. 204.
4. The Head Start program heavily emphasizes parent involvement through using parents as volunteers at the program centers, and, as well, attempts to assess and meet the needs of the family as a whole.
5. For 1983, the federal poverty income level was set at an annual income of $10,200 for a family of four, with $1,740 added for each additional family member.
6. Berrueta-Clement, Schweinhart, Barnett, Epstein and Weikart, *Changed Lives.*
7. *Ibid.*
8. *Ibid.*
9. Alfred J. Kahn and Sheila B. Kamerman, letter, *The New York Times* 18 September 1984.
10. *Ibid.*
11. *Ibid.*
12. Based upon data reported in *Adolescent Pregnancy Program Proposal* (Trenton, NJ: New Jersey Department of Human Services, Division of Public Welfare, 1983), p. 46.
13. This is a national problem too, as documented by the U.S. Congress, House, Select Committee on Children, Youth and Families, *Children, Youth and Families: 1983, A Year-End Report* (Washington, DC: U.S. Government Printing Office, 1984), pp. 34-35.
14. *Ibid.*
15. *Ibid.* Also, national statistics indicate that at least 50 percent of all women who first gave birth before the age of 18 do not complete high school *and* the annual income of a woman who gave birth as a teen is half that of her counterpart who first gave birth in her twenties. Elizabeth McGhee, "Teenage Parents, Causes and Consequences," *New Generation,* Vol. 62, No. 3 (Fall, 1982).
16. This is based upon estimates provided by the New Jersey Department of Human Services for 1984. According to the Department, caseload statistics for 1983 show that 6,148 of the AFDC mothers in 1983 were between 14 and 18 years of age.
17. Estimated cost per child for Fiscal Year 1985.

CHILD CARE SERVICES: MEETING THE GROWING NEED

Child care needs are largely unmet in New Jersey and the demand for child care services is rapidly increasing. Further, planning for child care services has been impeded by the fact that a comprehensive needs assessment has not been done to identify the full extent of the need.

- GROWING UNMET NEED FOR CHILD CARE
- MANY CHILDREN RECEIVE MARGINAL OR NO CARE
- NO COMPREHENSIVE NEEDS ASSESSMENT TO GUIDE PLANNING EFFORTS
- FEDERAL CUTBACKS HAVE ADVERSELY AFFECTED SERVICES
- INFORMATION AND REFERRAL SYSTEM NEEDED
- NEW INITIATIVES

Princeton Packet. Andrea Kane. Photographer

The demand for child care services for New Jersey's children is soaring, and for many of the state's one million families, child care has become an economic and social necessity. Further, as Governor Thomas H. Kean reported to the U.S. House Select Committee on Children, Youth and Families:

> The demand for day care is becoming comparable . . . to the demand for education and for medical care. Our response to date . . . has not caught up with the growth and the pervasiveness of the demand.[1]

GROWING UNMET NEED FOR CHILD CARE

The Commission on Children's Services found child care needs largely unmet in New Jersey.[2] For example, data reported by the New Jersey Department of Labor show that almost one million of New Jersey's children, aged infancy to 13 years, have working mothers; of this group, nearly half are preschool age children.[3] However, organized center-based care is available to less than 20 percent of the children whose mothers work.[4]

New Jersey's problem is reflective of the national scene. As documented by the Children's Defense Fund in their analysis of the President's FY 1985 budget:

> The availability of child care lags so far behind the demand for it that approximately 7 million children 13 years old and under, or more than one in six, may be going without adult supervision for part of each day. The need for infant care is climbing as is the demand for after-school programs. As more parents of young children work, child care needs will become an even greater problem.[5]

MANY CHILDREN RECEIVE MARGINAL OR NO CARE

Little is known about the kind of care received by those New Jersey children who are not enrolled in center-based programs.[6] Many children receive either marginal or no supervised care at all while their parents work. In fact, recent estimates suggest that as many as 250,000 elementary school children have joined the ranks of "latchkey" children,[7] those who care for themselves both before and after school while their parents work.

NO COMPREHENSIVE NEEDS ASSESSMENT TO GUIDE PLANNING EFFORTS

Planning to meet child care needs in New Jersey has been impeded by the fact that a comprehensive needs assessment has not been done to assess the full extent of child care needs. Data has not been analyzed to show needs by age groups, geographical areas and income levels.

Thus, despite strong interest on the part of parents, employers and state government in increasing the availability of child care, a plan of action based on priority needs has not been implemented. However, there is an existing array of child care services, some of which have been developed with state funding.

FAMILY DAY CARE

Child care comes in many forms. There is **family day care,** which by definition covers care given to up to five children of any age in a private home. Relatively inexpensive, family day care offers flexibility and convenience, and provides infant care, extended day care and "special needs" care, all of which can be otherwise hard to find.

Nationally, all but five states either license or regulate family day care. New Jersey is one of the five. One result is that **there is neither a comprehensive listing of family day care homes in New Jersey nor any guarantee that those which do exist here, independent of sponsoring agencies, are safe or healthy environments for children.** (Although family day care homes are subject to the provisions of the State Uniform Construction Code, it is estimated that up to 80 percent of all such homes are part of an "underground" and are not being inspected.) The Family Day Care Organization of New Jersey which oversees about 500 homes serving some 2,000 children, is vitally concerned with these issues, as are the Division on Women's Task Force on Child Care, Division of Youth and Family Services (DYFS) and the Association for Children of New Jersey. These groups and others are monitoring legislation which has been proposed on the licensing and regulation of family day care homes.

CENTER-BASED CARE: 1,600 LICENSED CENTERS IN NEW JERSEY

In addition to family day care there is **center-based care.** According to the Division of Youth and Family Services latest listing, there are more than 1,600 licensed centers serving an estimated 100,000 different children in New Jersey.[8] Closely monitored by DYFS, these centers provide programs and quality care, but only about one-quarter offer care for infants and toddlers. Costs vary considerably, and availability is a problem.

FEDERAL CUTBACKS HAVE ADVERSELY AFFECTED SERVICES

Service cutbacks are also a reality and, as always, those hit hardest are the poor and the growing number of the working poor. And, as reported by the Children's Defense Fund, federal budget cuts since 1981 have impacted severely on the availability of child care through decreases in funding for direct services, nutritional services, and staffing. According to CDF:

> Title XX, the largest program providing federal support directly for child care, has been cut 21 percent. Child nutrition programs that provide meals to children in child care centers and homes have been slashed by 30 percent. The Public Services Employment Program of the Comprehensive Employment and Training Act (CETA), which used to provide staff for child care centers, has been abolished. Child Care support available to poor families through the Aid to Families with Dependent Children (AFDC) program has been reduced. The numerous federal programs that

> support Head Start and its families—including AFDC, Food Stamps, Medicaid, and the Special Supplemental Food Program for Women, Infants, and Children—have been cut.
>
> As a result of federal budget cuts, 32 states provided child care to fewer poor children in 1983 than in 1981; 33 states decreased child care funding. In just three years, total combined federal and state spending for Title XX child care dropped 14 percent.[9]

New Jersey, unlike most other states, has not drastically cut child care services in response to the federal budget cuts. Rather, despite a $3 million loss of funding which reduced available child care funds to $35.7 million, the State has attempted to maintain the same number of available slots.[10]

However, the budget cuts have forced a reduction in the accessibility and quality of New Jersey's child care services and also have resulted in an increase in fees for use. According to information reported by the Association for Children of New Jersey in 1983 in *Through the Safety Net,* child care centers have had to implement staff and program reductions. Further, as a result of the cuts in Title XX monies, funding for after-school programs has been reduced severely.[11]

FEDERALLY FUNDED COMPREHENSIVE CARE: HEAD START

Head Start, a developmental program, is another form of comprehensive child care. Federally funded, the program is mandated to address the health, education, nutrition, mental health, social services and special needs of its population (children 3-5 years old, at least 90 percent of whom come from income eligible families and 10 percent of whom are handicapped children). Currently, Head Start programs are only able to serve 1 out of 5 eligible children in New Jersey (annual cost of $2,217 per child, FY '83).[12] There simply are not enough slots. This means 83 percent of the Head Start eligible children in New Jersey, some 45,000 children, are going without comprehensive child care services.

EXTENDED DAY CARE

Extended day care programs are designed to meet the needs of the so called "latchkey children," children whose parents work and who are thus on their own before and/or after school. No one is quite sure of the extent of the latchkey population in New Jersey, although we do know that there are about 500,000 mothers in the labor force with school-age children under the age of 18.[13] Some school districts have extended day programs, and nationally the YMCA is a leader in the provision of these services. Like family day care, extended day care services in all areas need to be first identified and then properly encouraged and monitored. The dangers to society and to the children themselves if this is not done cannot be overstated.

A special form of extended day care is also needed to provide temporary child care for children who are unable to attend school on a regular day care program because of illness. Often, employed parents must miss substantial blocks of time to remain home with a child who is not seriously ill because alternative care is not available. Temporary child care services would alleviate this problem.

EMPLOYER-SPONSORED DAY CARE: SLOW BUT STEADY PROGRESS

Employer-sponsored or employer-operated child care is a developing form of care. Currently, 21 New Jersey businesses, 15 of them hospitals, support or offer child care services. Others are in the process of developing centers or information and referral systems for their employees. While progress is slow, there is progress, and legislation designed to assist in these ventures has been introduced in New Jersey.

INFORMATION AND REFERRAL SYSTEM NEEDED

What is not yet happening, is the development either at the Federal or the State level of a centralized information and referral (I&R) system which could advise parents of available services and which could also provide technical assistance to anyone—corporations, nonprofit organizations, churches, individuals—who wanted to start child care services or to identify existing laws and services. The State, one of the largest employers, has an opportunity to be the leader in these endeavors.

SPECIALIZED CHILD CARE NEEDS

Further, **specialized child care** needs which are not employment-related have not been addressed in planning efforts. For many families and children, child care is needed to alleviate specific stresses upon the family. Child care services should be readily available for children at risk of abuse because of family problems. Additionally, respite child care is needed to ease the stress upon parents caring for a seriously handicapped child whose needs, because of medical or emotional disabilities, place extraordinary demands upon the parents.

NEW INITIATIVES

One promising new initiative in New Jersey is P.L. 1983, C.492, which provides for licensing of child care centers. The law, effective May 16, 1984, also **established an Advisory Council to DYFS and the Division on Women** to provide ongoing review of child care issues.

While Chapter 492 is a step in the direction of improving New Jersey's child care services, currently the services are woefully inadequate to meet the increasing need. Much remains to be done to assure that safe, available, affordable, reasonably convenient quality child care is available for all who need it.

RECOMMENDED ACTIONS

I. STATE LEADERSHIP IN ASSURING AVAILABILITY OF CHILD CARE SERVICES

The state should take a leadership role in assuring that safe and affordable child care is available for the children of parents who work. Further, sufficient child care services should be available for those children at risk of abuse and neglect, and to provide respite care for children whose handicapped conditions place on-going stresses upon their families.

II. COMPREHENSIVE PLAN GUIDED BY NEEDS ASSESSMENT

The new Advisory Council on Child Care should be directed to:

A. Conduct a comprehensive needs assessment to determine the full extent of child care needs in New Jersey by age groups, geographical location and income levels. This needs assessment should specifically examine the need for extended day care services for "latchkey" children, and the need for specialized child care services for abused children as well as for handicapped children.

B. Develop a comprehensive plan for meeting child care needs. This plan should specify priorities for developing additional child care services, and should include use of innovative approaches such as expanded use of local schools for child care services, use of neighborhood centers/agencies, and use of volunteer organizations.

III. CENTRALIZED INFORMATION AND REFERRAL SYSTEM

The new Advisory Council on Child Care should be given responsibility for establishing a centralized information and referral system to maintain an inventory of available child care services; to provide information on available services to parents; and to provide technical assistance for child care providers or others interested in developing child care programs.

IV. PROMOTE DEVELOPMENT OF EMPLOYER-SPONSORED CHILD CARE SERVICES

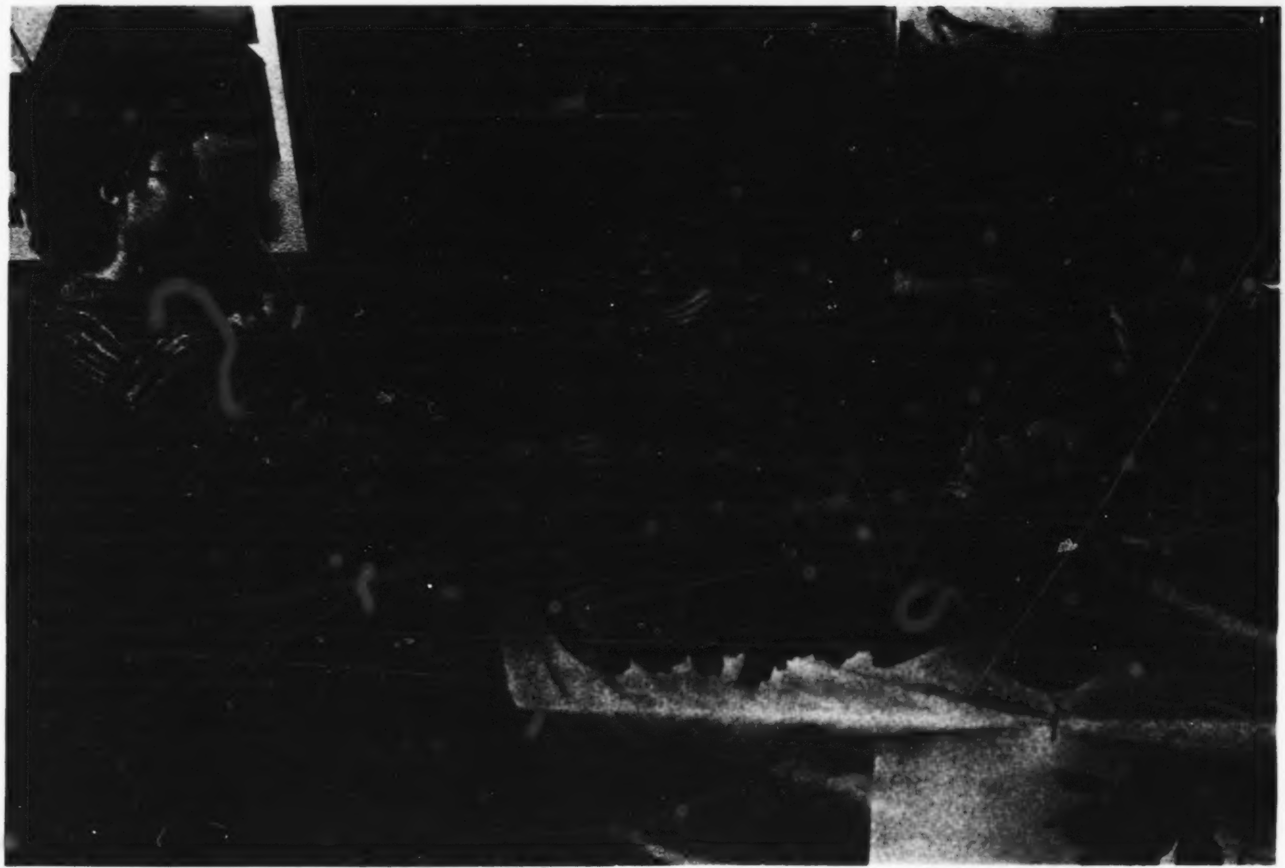
The state should assume a strong leadership role in promoting the development of employer-sponsored child care services, and should provide incentives to employers to encourage them to support services. Further, the state, as one of New Jersey's largest employers, should provide leadership on this issue by convening the proposed Inter-Departmental Committee on Child Care which has been recommended to study the need of state government employees for child care services and to make recommendations to meet the need.

NOTES

1. Governor Thomas H. Kean, testimony before the U.S. Congress, House, Select Committee on Children, Youth and Families, September 5, 1984.
2. R. Alexandra Larson and Carol Kasabach, *Linking Policy with Need* (Trenton, NJ: New Jersey Commission on Children's Services, 1982), p. 99.
3. New Jersey Department of Labor, *Child Care in New Jersey* (Trenton, NJ: 1979).
4. This estimate was provided by the New Jersey Department of Human Services, Division of Youth and Family Services.
5. Children's Defense Fund, *A Children's Defense Budget* (Washington, DC: 1984), p. 160.
6. This was the finding of the New Jersey Department of Labor in 1979, *Child Care in New Jersey*, p. 9. Although there has been considerable concern since the release of that report about the quality and type of care provided for those children who are not enrolled in licensed child care centers, there remains a paucity of information about the issue.
7. Eileen Steward, (Director of the Camp Fire Girls and Boys Council, Trenton, New Jersey), statement as reported by Benilde Little, " 'Latchkey' Children a Dilemma of Modern Life," *Star Ledger*, 24 June 1984.
8. Data provided by the New Jersey Department of Human Services, Division of Youth and Family Services as based upon 1983 statistics.
9. Children's Defense Fund, *A Children's Defense Budget*, pp. 160-161.
10. In order to compensate for the losses in federal funds, New Jersey implemented a sliding scale fee for child care services. The fee schedule is based upon the income and family size. Although the fees are rather minimal (from $2 to $18 a week), some children have been cut from child care centers because their families could not afford the fees. See: Shirley Geismar, Tricia Fagan and Patricia Deignan, *Through the Safety Net: A Citizen's Report on New Jersey Children and Families in Need* (Newark, NJ: Association for Children of New Jersey, 1983), p. 27.
11. *Ibid.*, p. 29.
12. U.S. Department of Health and Human Services, Office of Human Development Services, Administration for Children, Youth and Families "Project Head Start Statistical Fact Sheet" (April, 1983).
13. New Jersey Department of Labor, *Child Care in New Jersey*, p. 7.

V.

- EARLY INTERVENTION SERVICES FOR HANDICAPPED CHILDREN
- MENTAL HEALTH SERVICES FOR CHILDREN
- PREVENTION AND TREATMENT TO STEM THE PROBLEM OF SUBSTANCE ABUSE
- THE JUVENILE JUSTICE SYSTEM AND THE FAMILY COURT: DEVELOPING PREVENTIVE SERVICES AND COST EFFECTIVE ALTERNATIVES FOR TROUBLED CHILDREN, YOUTH AND FAMILIES



Princeton Packet, Paul Savage, Photographer

ACTIONS TO ADDRESS PHYSICAL, EMOTIONAL AND BEHAVIORAL DISORDERS

INTRODUCTION

Most New Jersey children reach adulthood free of seriously disabling physical or emotional problems. But, substantial numbers of the state's children are either born or afflicted during childhood with major physical or emotional problems which, if left untreated, can result in life-long disabilities and dependency.

Further, many of the state's young people are today at risk of the harm resultant from either their own or their parents' abuse of alcohol or other mood altering substances. Additionally, thousands of young people are evidencing troubled behavior which results in their being brought before the courts either because their families cannot cope with them or because they have committed a criminal offense.

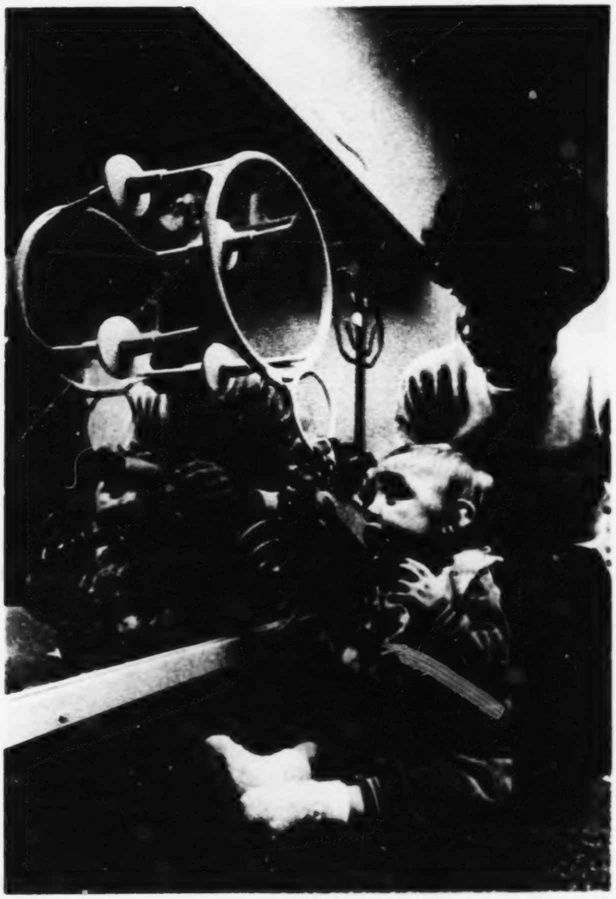
This chapter reports the Committee's recommendations for the planning and provision of services to prevent as well as treat physical, emotional and behavioral disorders among New Jersey's young people. The recommendations include actions to provide:

- Early intervention services for handicapped children.
- Mental health services for emotionally disturbed children.
- A continuum of prevention and treatment services to stem the problem of substance abuse.
- A full range of programs for troubled children, youth and families whose problems might result in their being brought before the Family Court.

EARLY INTERVENTION SERVICES FOR HANDICAPPED CHILDREN

About 4,000 New Jersey children under three years of age require early intervention services to alleviate handicapping conditions which may impede their ability to learn and function in a school setting. Services are available for only half of the eligible children in 1985 and, while plans were made to further increase the number of children served during the next fiscal year, these plans are dependent upon the provision of additional funding. Further, there are several problems which affect the provision of services: inadequate transportation provisions; insufficient outreach; and lack of agreement about the composition of the core team for services.

- GAPS IN SERVICES
- INSUFFICIENT OUTREACH



UMDNJ George Kemper Photographer

Currently, there are an estimated 4,000 New Jersey[1] children under the age of three years who require early intervention services to alleviate handicapping conditions which may impede their ability to learn and function in a school setting. In 1984, services were made available for 1,161 or 29 percent of these children.

The Commission on Children's Services recognized in its report, *Linking Policy with Need,* the importance of early services for young, handicapped children. Further, in 1981 Chapter 415 was enacted to provide services for this population and this law called for statewide planning of services under the leadership of the Department of Education in collaboration with the Departments of Health and Human Services. Chapter 415 states in part that "each board of education shall provide information to the parents of handicapped children below the age of three regarding available services and programs provided by other State, County or local agencies which may prevent their handicap from becoming more debilitating."[2]

Since the enactment of Chapter 415, the Departments of Education, Health and Human Services have made substantial strides in developing a network of early intervention programs for very young handicapped children. These programs use a comprehensive, interdisciplinary approach designed to meet the physical, sensory, communication, cognitive and social-emotional needs of the children. A team of professionals evaluates the needs of the child, and then implements a plan of services which includes working with the child and the parent.

While the state's capacity to provide programs for eligible handicapped children has rapidly grown, there are still gaps in services and additional programs are needed. Further, these additional problems affect the provision of services: inadequate transportation provisions insufficient outreach; and lack of agreement about the composition of the core team.

GAPS IN SERVICES

During this first year of implementation of Chapter 415, 34 interdepartmentally funded early intervention programs are operating to provide services for 1,161 of the 4,000 eligible children. To assure that all of the eligible children will have the opportunity for services, the Department of Education has developed a phase-in plan to increase the number of children served to 2,000 in FY 1984-85 and then to 4,000 in FY 1985-86. But, this phase-in plan can only be fully implemented if sufficient funding is appropriated to expand the service network.

Although all counties have at least one early intervention program, children in some counties are not served because of factors such as lack of appropriate staff, accessibility problems due to lack of transportation, and a lack of existing programs to build upon. Furthermore, infants at risk of developmental delay because of environmental or health factors alone are not eligible for the services.[3]

INSUFFICIENT OUTREACH

Parents have a difficult time learning about early intervention services and programs. There is insufficient awareness of the existence of these programs on the part of both parents and potential referral sources. In some instances, there is inadequate outreach by programs providing services as well as the state funding agencies.

DATA COLLECTION MECHANISM

A data collection mechanism does not exist to adequately gather and analyze data needed to do comprehensive statewide planning and program evaluation.

CORE TEAM MEMBERSHIP

There continues to be some disagreement about core team membership. Currently, approval criteria require that members of the interdisciplinary core team be selected from the following specialists: physical therapist, occupational therapist, speech and language pathologist, registered nurse, social worker, psychologist, special education-early childhood teacher, and other specialists as needed.[4] Some feel that other specialists, such as the child psychiatrist, developmental pediatrician, and learning disability teacher/consultant, should also be required on the core team.

Not enough appropriately trained and credentialed professionals are available to staff New Jersey early intervention programs.[5] Too few academic programs exist in the state to train such personnel. For example, at present, only one New Jersey college trains physical therapists, yet they are an important part of the early intervention program.

INTER-DEPARTMENTAL COOPERATION

The Committee endorses wholeheartedly the present efforts of the state departments developing and implementing early intervention programs. Further, it endorses the principle that an interdisciplinary approach is the best one to address the complex needs of the handicapped infant and child. Thus, it supports the continued cooperative efforts of the Departments of Education, Health and Human Services to assure that early intervention services are provided for all children who need them.

RECOMMENDED ACTIONS

I. FUNDING

The state should provide sufficient funding for continued support of the Department of Education's proposed phase-in plan which would provide services for all eligible children by FY 1985-86.

II. TRANSPORTATION

Transportation needs should be carefully assessed and appropriate measures should be taken to assure that programs are accessible for all eligible children, especially those in rural and inner city areas where transportation problems are most common.

III. IMPROVED OUTREACH

Improved methods of outreach should be developed to ensure early referral of all eligible children. A concrete outreach plan should be developed and implemented by both state and local agencies.

IV. DATA COLLECTION

A data collection mechanism which organizes and analyzes the data necessary for comprehensive statewide planning and evaluation should be established. The mechanism should utilize all existing data which is currently being collected by various agencies.

V. CORE TEAM

The current compositon of the core team should be maintained, and the specific inclusion of other specialists, such as the child psychiatrist, developmental pediatrician and learning disability teacher/consultant should be encouraged where appropriate to meet the child's needs.

VI. ROLE OF PHYSICIANS

Physicians should have a role in both the diagnostic and prescriptive phases of early intervention programs. This involvement should include case follow-up after implementation of the service plan to assess the efficacy of the services.

VII. NEED FOR PROFESSIONALS

The Department of Higher Education should, in concert with the Departments of Education, Health and Human Services, assess the need for trained professionals in early intervention programs, and take appropriate steps to increase the available pool of needed professionals.

VIII. STUDY OF AT-RISK CHILDREN

The Departments of Education, Health and Human Services should conduct an in-depth study of the "at-risk" infant population and identify those factors which might contribute to placing a child at risk of developmental delay. Further, the three departments should examine the feasibility of expanding the eligibility criteria for early intervention programs to include infants and children at risk of developmental delays from health and environmental factors alone.

IX. CONTINUE INTER-DEPARTMENTAL CO-OPERATION

The close cooperation among the Departments of Education, Health and Human Services in planning and implementing early intervention programs should be continued.

NOTES

1. New Jersey Department of Education, Division of Special Education, *Population Study for Early Intervention Programs in New Jersey, 1982* (1982).
2. N.J. STAT. ANN. 18A:46-6.
3. Much of the foregoing descriptive information regarding the Early Intervention Program was obtained from Jane Chazkel Hochman, (Educational Program Specialist, Bureau of Programs and Services, New Jersey Department of Education).
4. "Approval Criteria for State of New Jersey Interdepartment Application for Early Intervention Program Funding," October, 1984 which is authorized by N.J.A.C. 6:28-10.1-10.3.
5. Jane Chazkel Hochman, (Educational Program Specialist for the Bureau of Programs and Services, New Jersey Department of Education), provided information.

MENTAL HEALTH SERVICES FOR CHILDREN

This section reports the Governor's Committee's recommendations for mental health services for children. Two service issues are addressed:

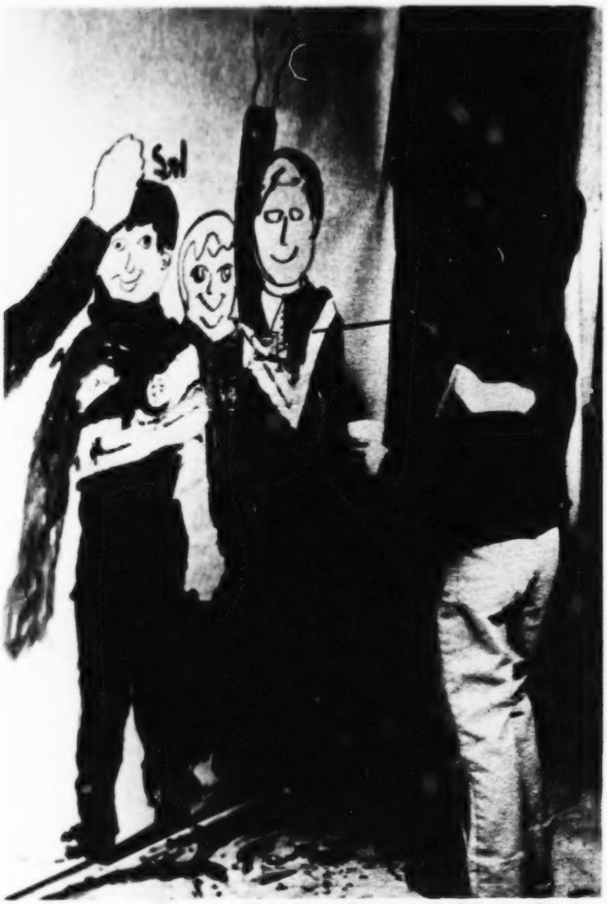
- COMMUNITY-BASED SERVICES
- SPECIALIZED SERVICES FOR EMOTIONALLY DISTURBED JUVENILE OFFENDERS

Princeton Packet, Rich Pipeling, Photographer

COMMUNITY-BASED MENTAL HEALTH SERVICES FOR CHILDREN

Although substantial progress has been made in improving the overall quality of mental health services for children, many emotionally disturbed children still do not have access to the services they need. Further, there are indications that a fair proportion of the available federal and state funds for community-based services are not being allocated to services for children. Additionally, there are an insufficient number of partial care programs to serve those children who require intensive, daily services to enable them to remain in the community.

- INSUFFICIENT COMMUNITY SUPPORT SERVICES
- INADEQUATE PLANNING AT COUNTY LEVEL
- STEPS NECESSARY TO IMPROVE COUNTY PLANNING
- ADDITIONAL PARTIAL CARE PROGRAMS NEEDED



New Jersey Department of Human Services

There are many emotionally troubled children in New Jersey who require remedial services, and many families who need support to cope with the problems of troubled children in their care. For example, data reported by the New Jersey Department of Education for its 1982-83 plan show that nearly 15,000 school-age children evidence problems so severe as to warrant them being classified for educational purposes as emotionally disturbed.[1]

Additionally, more than 1,000 New Jersey children receive care in residential centers or psychiatric hospitals each year. Further, the rate of suicide among New Jersey's young people has been on the rise, and suicide is now the second leading cause of death among the state's adolescents.[2]

In recent years, substantial progress has been made in improving the overall quality of mental health services for children, and since 1978, New Jersey has greatly reduced its reliance upon state psychiatric institutions for children by expanding community-based services for very troubled children. In fact, New Jersey's deinstitutionalization effort was recognized by the Children's Defense Fund in a 1982 national survey of children's mental health services.[3] However, as the Commission on Children's Services reported, many emotionally disturbed children still do not have access to the services they need.

Further, there are indications that a fair proportion of the federal and state funds provided to the counties for community mental health services is not being allocated to services for children. For example, although children represent 27 percent of the state's population, they represent only 18 percent of the clients served at community mental health centers. Additionally, of the $39.5 million budget provided through the Department of Human Services to the counties for community services, only $6.8 million or 17 percent is spent for children.[4]

INSUFFICIENT COMMUNITY SUPPORT SERVICES

It has been postulated that children evidence less need for mental health services than adults, and consequently a smaller proportion of children than adults come to mental health centers and other agencies for psychiatric services. However, public officials and community members from across the state have consistently reported that sufficient support services are not provided at the community level for emotionally troubled children and their families, some of whom need highly specialized and intensive services.[5]

INADEQUATE PLANNING AT COUNTY LEVEL

In recognition of the need to improve the quality and quantity of community-based mental health services for children, the Department of Human Services, through its Division of Mental Health and Hospitals (DMHH), now requires the counties to explicitly identify children as a target population in developing the county plans for use of federal and state funds for mental health services.[6] But, while some counties have placed increased emphasis on children's needs, other counties continue to give them only minimal attention.

Unless this pattern is corrected, substantial numbers of troubled children and their families will not receive the kind of support services necessary to enable these children to function in the community without posing a risk to themselves or other community members. Further, in many cases, the absence of effective, community-based support services will result in serious familial problems which may cause severe family dysfunctions and even the outright rejection of the troubled child.

STEPS NECESSARY TO IMPROVE COUNTY PLANNING AND PROVISION OF SERVICES

Several steps can be taken to assure that the counties take action to assess and meet the mental health needs of children. As a starting point, the county mental health boards, which have responsibility for planning the allocation of funds, could be required to develop a special planning process focused on children's needs. Specifically, the boards could be required to establish children's advocacy committees to assess and represent children's needs in the planning process.

As an additional step, DMHH could require the counties to allocate to children's services a specific percentage of the additional per capita funding the state is providing to the counties for mental health services. Annually, the counties have each received $1.00 per resident for mental health services. This special fund, established by law in 1957, is now being increased over a period of three years by gradually raising the per capita rate to $2.00.[7]

Although it would be difficult for the counties to shift funds received under the base per capita rate of $1.00 since these funds tend to be committed to specific ongoing projects, a portion of the additional funds obtained because of the increase could be targeted to children. In view of the fact that children represent 27 percent of the population, the counties could be directed to set aside for children at least 27 percent of the new funds.

These steps can facilitate the expansion of community-based counseling and other out-patient services for troubled children and families. However, more intensive services are needed as well to serve severely disturbed children.

ADDITIONAL PARTIAL CARE PROGRAMS NEEDED

In some instances, the most effective way to meet the needs of a severely disturbed child is through placement in a therapeutic setting such as a hospital or a residential center. But, removing children from their homes often has socially and psychologically harmful consequences, and professionals widely agree that it is frequently preferable for the child to remain in her/his own community.

Partial care progams, which provide treatment services along with daily therapeutic supervision for troubled children, can avert the need for out-of-home placement for those children who require intensive day-to-day services. Partial care programs are a particularly favored alternative to residential placement because they:

- In contrast to out-of-home placements, spare children the pain of separation from family and community.
- Spare children the stigma associated with out-of-home placements.
- Do not pose a danger that children and parents will grow further estranged while apart.
- Retain the opportunity—critical since the problems of so many children are rooted in disturbed family relations—to engage parents and siblings in treatment.
- Are able to concentrate on shaping new behavior in the setting in which new behavior is most needed.
- Are able to take advantage of community resources and prepare children and their families to take advantage of them.
- Provide treatment comparable to that provided by psychiatric hospitals and residential schools but at less cost.

In light of those arguments DMHH has committed itself to reducing the number of children in psychiatric hospitals. Since 1979 it has thus closed the children's units at three psychiatric hospitals. Further, it has established contracts with a number of community-based mental health agencies to provide partial care services.

However, as the Commission on Children's Services reported,[8] there is still a lack of community-based partial care and day treatment programs for children. That has several troubling consequences:

- Children still must be placed out of their homes because community-based mental health services are not available.
- Many troubled children remain at home but receive inadequate care and treatment—and sometimes no care and treatment at all.
- Many children return from out-of-home placements only to be deprived of aftercare services.

Partial care programs are not all of a kind. They differ in the types of children they serve, the kinds of treatment provided and the level of involvement with the child's family.[9] Some programs focus on center-based care, while others such as the Homebuilders model established in the state of Washington, focus on working with the child and the parents in the home. Where implemented, programs such as these have proven to avert the need for hospitalization and resulted in considerable savings. For example, in one program year the Homebuilders program served 52 children who were initially assessed as needing placement in a psychiatric hospital; of these children, 41 were served without resorting to placement. At an average cost of $5,000-$5,500 per child, the program cost for 1980 was only 22 percent of the $25,000 per child cost for care in a Washington State psychiatric hospital.[10] In New Jersey, the 1984 cost per child for care in a state psychiatric facility was over $36,000; the cost for 1985 is estimated at over $39,000.[11]

While community agencies and schools may, in some communities, be able to provide resources for partial care programs, in most instances some fiscal support and technical assistance would be needed from the state to develop additional partial care programs. DMHH has to date served as the lead agency for the development of mental health servies for children, including partial care programs, and could, with additional funding, spur the development of new programs in those geographical areas where there are substantial numbers of unserved troubled children.

RECOMMENDED ACTIONS

I. COUNTY PLANNING AND FUNDING OF SERVICES

The counties should be required to place additional emphasis on identifying children's needs for mental health services, and planning community services for them. Further, a fair proportion of available federal and state funding for community mental health services should be allocated to services for children. To this end, these steps should be taken:

A. Legislation should be enacted to require each county mental health board to establish a children's advocacy committee to assess and represent children's needs in the county planning process.

B. The Department of Human Services through its Division of Mental Health and Hospitals (DMHH) should take administrative action to assure that at least 27 percent of the new funds provided by the increase in the per capita funds for mental health services be allocated to services for children in the community.

II. ESTABLISH ADDITIONAL PARTIAL CARE PROGRAMS FOR TROUBLED CHILDREN

The state should through DMHH provide fiscal support and technical assistance for the development of additional community-based partial care programs for emotionally disturbed children at risk of institutional placement, and for children returning home from psychiatric facilities, residential schools and other out-of-home placements.

NOTES

1. New Jersey Department of Education, *1982-83 Annual Plan for the Education of All Handicapped Children* (Trenton, NJ: 1981).
2. Statistics from the New Jersey Department of Health cited by Tom Rosenthal (Associated Press), "Teenage Suicides: NJ Aid Sought," *The Home News*, 4 September 1984.
3. Jane Knitzer, *Unclaimed Children—The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services* (Washington, DC: Children's Defense Fund, 1982).
4. Estimate for FY 1984-85 provided by the New Jersey Department of Human Services.
5. This was reported to the New Jersey Commission on Children's Services through testimony and interviews, R. Alexandra Larson and Carol Kasabach, *Linking Policy with Need* (Trenton, NJ: New Jersey Commission on Children's Services, 1982). Similar observations were reported to the Governor's Committee on Children's Services Planning.
6. The New Jersey Department of Human Services established this requirement in 1980.
7. N.J. STAT. ANN. 30:9A-9.
8. Larson and Kasabach, *Linking Policy with Need*, pp. 107-108.
9. For additional information on promising models, see Knitzer, *Unclaimed Children*, chpt. II.
10. *Ibid.*, p. 31.
11. These are the budget figures reported for the state-operated Arthur Brisbane Child Treatment Center, *State of New Jersey Budget—Fiscal Year 1984-85* (Trenton, NJ: 1984), p. 185.

SPECIALIZED SERVICES FOR EMOTIONALLY DISTURBED JUVENILE OFFENDERS

Many of the children committed to the Department of Corrections (DOC) have psychological problems, and substantial numbers of these children have serious psychiatric disorders. However, DOC does not have the resources to provide the necessary treatment services for these children and, as a result, many of these children are ultimately released to the community with serious, unabated emotional problems.

- MANY INCARCERATED YOUTH HAVE EMOTIONAL PROBLEMS
- TREATMENT NEEDS ARE NOT MET
- SERIOUS EMOTIONAL PROBLEMS ARE EXACERBATED
- INNOVATIVE, COORDINATED EFFORTS ARE NEEDED

Anatol Kurdsjuk, Photographer

Todd is 15 years old and was committed to DOC for sodomy. He is psychiatrically fragile and has a below average I.Q. He has a previous arrest record for deviant sexual behavior with young boys.

Robert is 16 years old and was committed to the correctional system for robbery. He is impulsive and self-punitive. Twice he has been hospitalized for depression and attempted suicide.[1]

MANY INCARCERATED YOUTH HAVE EMOTIONAL PROBLEMS

As a recent study demonstrated, only a small portion of the children committed to New Jersey's correctional facilities are merely delinquent. Most also have psychological problems.[2] Some, like Todd and Robert, have emotional problems that are profound and debilitating and at the heart of their delinquency.

According to DOC, as many as 20 of the children committed each year are so disturbed that they required specialized services. Others, like Todd, require treatment services that currently are not available for children in New Jersey. Indeed, some of these children have had several prior hospitalizations in psychiatric facilities before being committed to DOC. Further, in some instances, the children have been reluctantly committed to DOC by the courts simply because alternative services were not available for them.

TREATMENT NEEDS ARE NOT MET

But, New Jersey's correctional facilities are not at all equipped to meet the treatment needs of children who have serious psychiatric disorders. The institutions' primary emphasis is on containing children who have violated the law, and the facilities simply are not structured to provide a therapeutic environment for seriously disturbed children. Further, DOC has not been given the funding to hire needed mental health staff and develop specialized services for these children. And, there has been little coordination between DOC and the mental health system to establish services for this population.

In fact, existing state psychiatric facilities are not currently able to provide on-going services for these children. Children who become psychotic in DOC facilities are transferred to state psychiatric facilities and then returned to DOC's custody after a brief period of treatment. Some children have had to be transferred back and forth from DOC to state psychiatric units as many as three times because of repeated psychotic episodes.[3]

SERIOUS EMOTIONAL PROBLEMS ARE EXACERBATED

So, instead of leaving the correctional facilities in a "rehabilitated" condition, many of these children are ultimately released to the community with serious, unabated emotional problems which may have even been exacerbated. And few after-care services are available for them after they have been released.[4]

INNOVATIVE, COLLABORATIVE EFFORTS ARE NEEDED

Many of these children do not benefit from traditional psychiatric services and they often do not "fit" into existing residential treatment programs for adolescents. Thus, to adequately meet the needs of this population specialized services using innovative approaches are necessary. Further, since the wide range of needs and problems evidenced by these children cannot be appropriately met by any one single program approach, an individualized service plan is required for each.

Other state agencies such as the Division of Mental Health and Hospitals (DMHH) and the Division of Youth and Family Services (DYFS) in the Department of Human Services have responsibility for providing services for troubled children. In addition, there are many local public and private agencies responsible for serving this population. However, little has been done in the way of on-going collaborative efforts to coordinate services and develop resources to serve those children who are committed to DOC. This type of coordinated planning will need to be done to develop the array of specialized services these children require.

PROBLEM NOT UNIQUE TO NEW JERSEY

This problem is not unique to New Jersey. In fact, one national review estimated that approximately 80 percent of the adolescents in the juvenile justice system are emotionally disturbed, and concluded that this population is grossly underserved because the responsible agencies have disparate service mandates and procedures. On the occasions when the juvenile justice and other service systems have come together, it was usually during a crisis, e.g. to develop a plan for one child in crisis rather than to develop procedures for ongoing collaboration among agencies.[5]

NEW DMHH PROJECT TO ADDRESS THE PROBLEM

In recognition that systemic problems have led to gaps in services for seriously disturbed children and youth, DMHH recently began implementing a special project to address the problems, the Child and Adolescent Service System Program (CASSP). This new initiative, supported by a federal grant, will be giving special attention to the needs of emotionally disturbed adolescents in the juvenile justice system.

The focus of CASSP is on developing collaborative relationships among different state and local agencies so that a comprehensive continuum of services can be established for this population. The project, which will also conduct a comprehensive needs assessment and provide technical assistance to other agencies, can provide a solid foundation for on-going teamwork among agencies in meeting the needs of very troubled juvenile offenders.

NEW COOPERATIVE EFFORT BETWEEN DMHH AND DOC

The CASSP staff has already begun working with DOC to assess the special needs of juvenile offenders and to identify gaps in services. They are also preparing to assist DOC in developing a process for providing individualized treatment plans for this population.

This special cooperative effort in effect provides a framework for a demonstration project of specialized services for severely disturbed juvenile offenders. This type of demonstration project could use an inter-agency advisory team to facilitate cooperation among agencies in both developing and providing innovative services.

While both DOC and DMHH see the need for this type of project, funds are not currently available to establish the very specialized services that some of the youth require. In order to properly serve these youth, DOC will need an estimated $800,000 annually to provide the services.

RECOMMENDED ACTION

ESTABLISH DEMONSTRATION PROJECT

A two-year demonstration project of specialized services should be established for 20 severely disturbed juvenile offenders who have been committed to the Department of Corrections (DOC). The sum of $800,000 should be appropriated to DOC for each of the two years to provide the services. Further:

A. ADVISORY TEAM TO DEVELOP SERVICES

An Advisory Team should be established by DOC to guide the development and provision of services. In addition to DOC staff, the Advisory Team should include representatives of: the Divisions of Mental Health and Hospitals and Youth and Family Services of the Department of Human Services; the appropriate divisions of the Department of the Public Advocate; and the Community Mental Health Agencies Association.

B. CASE REVIEW AND INDIVIDUALIZED PLANS

1. The Advisory Team should review the case of each youth referred for services and prepare an individualized plan of services for each youth who requires specialized services. The individualized service plans should be tailored to the unique needs of the youth, and should include use of innovative approaches drawn from models such as the Teaching Parent Program,

Outward Bound and therapeutic work experiences where appropriate. Emphasis should be placed on using the least restrictive services suitable for the youth, and the plan should also utilize services offered by community-based agencies wherever possible.

2. In reviewing the cases of youth referred for services, the Advisory Team should carefully screen each case to determine if the youth requires on-going services. If, after screening, it is apparent that a youth's primary problem is psychiatric as opposed to delinquency, the Team should report its findings to DOC and should make a recommendation for an alternative placement for the youth to be effectuated by recall of the Family Court.

C. EVALUATE PROJECT EFFECTIVENESS

An interim evaluation should be performed at the end of the first year of the project's existence, and a second evaluation should be done at the conclusion of the second year of the project to: assess the project's effectiveness in meeting the needs of the youth, identify on-going gaps in services for this population, and develop a profile of the characteristics of the youth referred to the project.

* * *

The Committee believes that this project would facilitate cooperation between DOC and other agencies who have responsibility for serving troubled youth. It expects, too, that the project would stimulate the development of innovative services which may be replicated by community-based agencies to serve young offenders who are emotionally disturbed.

NOTES

1. These case examples were provided by the Department of Corrections.
2. This was the finding of a study of the population completed in 1981. Harriet E. Hollander, Floyd Turner and William Stein, *Juveniles in New Jersey Correction Facilities: A Multi-Dimensional Report* (Piscataway, NJ: Community Mental Health Center, Rutgers University Medical School, 1981).
3. Formal data is not available to show the full extent of case "sharing" between the Department of Corrections and the state psychiatric facilities. The information reported here is based on case examples provided by the Department of Corrections.
4. Hollander, Turner and Stein, *Juveniles in New Jersey Correction Facilities.*
5. E. McKenzie and R. Roos, "The Mentally Disordered Juvenile Offender: An Inquiry into the Treatment of the Kids Nobody Wants," *Juvenile and Family Court Journal* (November 1979), pp. 47-57. See also: Jane Knitzer, *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services* (Washington, D.C.: Children's Defense Fund, 1982).

PREVENTION AND TREATMENT TO STEM THE PROBLEM OF SUBSTANCE ABUSE

Substance abuse is a pervasive problem in New Jersey, and today it probably affects more children and youth than any other single problem. But, a statewide policy has not been established to address the problem and affected children, youth and families do not have access to a continuum of preventive and remedial services.

- HUNDREDS OF THOUSANDS OF YOUNG PEOPLE AFFECTED
- INCREASING PATTERNS OF MULTIPLE AND COMBINED ABUSE
- DEVASTATING EFFECTS AND COSTS OF SUBSTANCE ABUSE
- PARENTAL SUBSTANCE ABUSE
- FETAL ALCOHOL SYNDROME
- CHILDREN GROWING UP IN THE CARE OF SUBSTANCE ABUSERS
- NO CLEAR STATEWIDE POLICY
- INSUFFICIENT PLANNING AND COORDINATION OF SERVICES
- LIMITED PREVENTION EFFORT
- PREVENTION PROGRAMS NEEDED FOR CHILDREN OF ALCOHOLICS
- INSUFFICIENT RESIDENTIAL PROGRAMS
- AFTER-CARE SERVICES NEEDED
- INSUFFICIENT OUT-PATIENT TREATMENT FACILITIES
- MEDICAL INSURANCE ISSUES
- COMPREHENSIVE PLANNING NEEDED

New Jersey Department of Human Services

Perceptions of a high school student . . .

DRUGS IN HIGH SCHOOL

I am going to be a Junior in high school and I am a drug addict and an alcoholic. Although it is hard to stay straight anywhere because drugs and alcohol are available almost anywhere, there is an abundance of almost any kind of drugs in almost every high school. Contrary to many peoples' beliefs, most of the drugs consumed in America are consumed by young people under the age of 21. In the high schools I've been in, most of the students used drugs to some degree, some like I did and others not so often.

In this day and age, drugs are considered by many people to be a form of recreation. As I've already said, drugs are very available in high school. Every drug from pot to cocaine can be found in high school. Drugs can be found in the usual places: bathrooms, hallways, empty classrooms, parking lots, etc. In public high schools there is not much supervision, so you can usually get away with using drugs in high school. (Although many people know that drugs are a problem in high school, not many people are willing to do much about it.)

For some people like me, it is extremely hard to go to high school and not have the urge to use. Sure, there are counselors there to help, but there is not much they can do about it. Many of the teachers are not that familiar with the use and abuse of drugs. Drug use and deals sometimes go on right inside classrooms. I know all about drugs in high school, because I've been there before. I used to be one of the head users and dealers of drugs in some of the schools I've been in. There really is not much that can be done about this problem, but what American high schools need is more supervision and more rules to make using drugs harder.

Substance abuse,* a problem which crosses all social and economic lines, may adversely affect more children in New Jersey today than any other single problem. In fact, estimates provided by the New Jersey Department of Health indicate that as many as 350,000 young people aged 12-17 years abuse either drugs or alcohol to varying degrees.[2]

Further, hundreds of thousands of children risk harm as a result of parental substance abuse. An estimated 20 to 40 percent of New Jersey's children live with a parent who abuses drugs or alcohol, and hundreds of infants are born each year with disabilities resultant from maternal substance abuse.[3]

Both the causes and results of substance abuse are complex, and the problem cannot be either prevented or alleviated by simple, neat solutions. Moreover, substance abuse affects all areas of human relationships, influencing family life, interpersonal relationships, industry and the professions, and society as a whole. Thus, multi-faceted strategies are necessary to prevent as well as alleviate the harm to children from substance abuse.

YOUNG PEOPLE AND SUBSTANCE ABUSE

HUNDREDS OF THOUSANDS AFFECTED

Over the past two decades, the incidence of substance use **and** abuse among young people has surged with the onset of use "most likely to occur during early adolescence."[4] Children from all backgrounds and communities are affected, and, according to a 1981 Department of Education report, "the practice is spreading from colleges and high schools to the junior high, middle schools, and even grade schools."[5]

National data reported by the U.S. House Select Committee on Children, Youth and Families show that 8 percent of all teenagers have a serious drinking problem, and an estimated 7-8 percent use marijuana daily.[6] If these figures hold true for New Jersey's youth in the 12-17 year old age group, over 62,000 New Jersey teenagers are problem drinkers and another 54,000 to 62,000 are using marijuana everyday. And, as the House Committee found, other drugs such as cocaine and amphetamines are used weekly by as many as 5 percent of the teenage population.[7]

While no one knows the full extent and nature of substance abuse among New Jersey's young people, two recent surveys of high school students conducted by the New Jersey Attorney General show that the vast majority have had some involvement with illegal substances. Over 91 percent of the high school students surveyed in 1980 reported using alcohol at some point in their lives, and 67 percent reported using an illicit drug. Another 43 percent reported using a substance other than alcohol or marijuana.[8] A second

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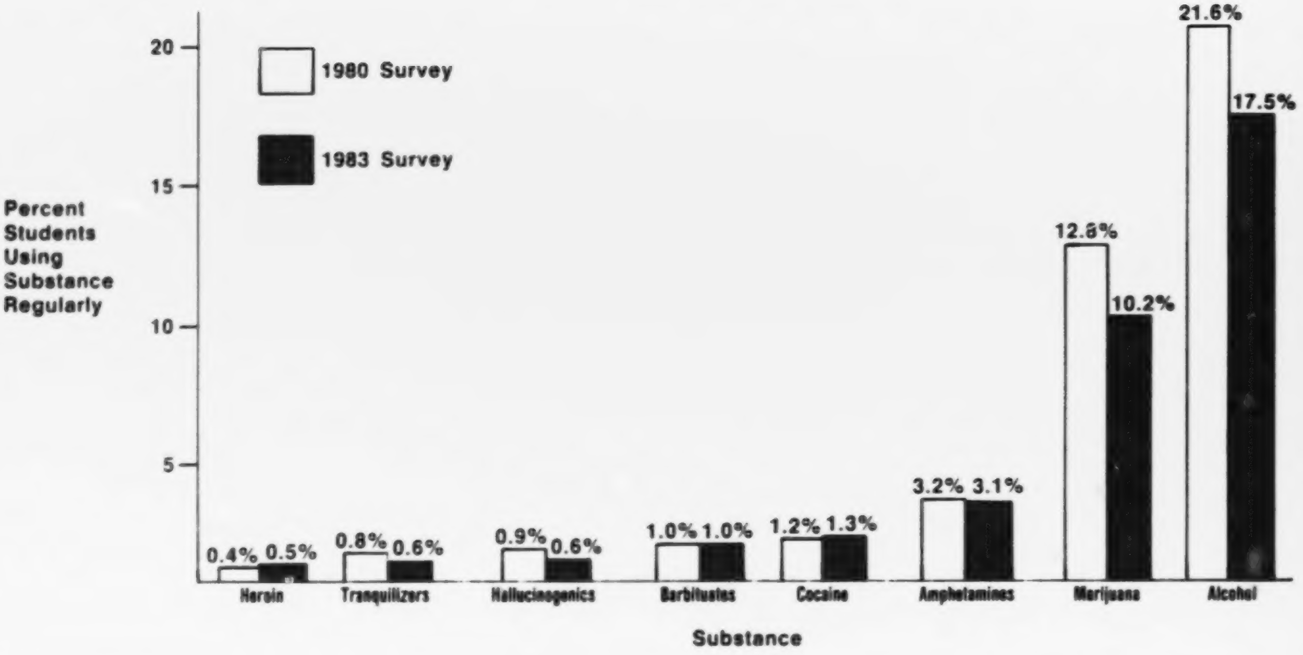
*Substance abuse is defined here as the use of any chemical which alters mood, brain function or perceptual ability taken in a manner differing from generally approved social or medical practices. Substances abused include alcohol, marijuana, tranquilizers, hallucinogenics, amphetamines, cocaine, opiates, phencyclidine (PCP), and inhalants such as solvents, aerosols, and glue.[1]

Graph 5.1

30 DAY PREVALENCE OF REGULAR USE* FOR EIGHT SUBSTANCES
SURVEY 1980 AND 1983



*Regular use defined as use on ten or more occasions in the last 30 days.

From: Wayne S. Fisher, *Drug and Alcohol Use Among New Jersey High School Students 1984* (Trenton, NJ: New Jersey Department of Law and Public Safety, Division of Criminal Justice, 1984).

1983 study found almost identical patterns of drug and alcohol exposure.[9]

Further, substantial numbers of the students reported **regular use** of alcohol and/or drugs. For example, as illustrated in Graph 5.1, nearly 18 percent reported use of alcohol on 10 or more occasions within the last 30 days and over 10 percent reported this pattern of marijuana use.[10]

And, there are strong indications that drug and alcohol use is common in New Jersey schools. Over one quarter of the students surveyed reported using drugs at least once during school hours, while over 16 percent reported using alcohol at least once during school hours.[11]

ALCOHOL THE MOST PREVALENTLY USED DRUG

Alcohol, the drug most readily available to young people, is the substance most widely used and abused by youth today.[12] Further, studies show that problem drinking commonly precedes use of drugs such as hallucinogens, cocaine, heroin and amphetamines.[13]

Binge drinking—uncontrolled drinking sprees—is also becoming popular among young people. For example, a recent national survey conducted by the National Institute on Alcohol Abuse and Alcoholism found that 54 percent of the teenagers viewed binge drinking as acceptable. Further, 41 percent of the teenagers who drink reported that they "binge," a practice which increases the likelihood of drunk driving, unwanted pregnancy and anti-social behavior.[14]

INCREASING PATTERNS OF MULTIPLE AND COMBINED ABUSE

While alcohol is the favored drug among teenagers, the incidence of multiple and combined use of two or more different substances is increasing. For example, a 1983 study of New Jersey students found that:

- Over 36 percent reported the combined use of either alcohol and drugs other than marijuana, or marijuana and other drugs.
- 12 percent reported the combined use of alcohol, marijuana and other drugs at least once.
- Nearly 11 percent reported the combined use of two illicit drugs other than marijuana.[15]

Also, there is increasing evidence of dual and multiple addictions. In fact, one residential center which treats about 400 New Jersey youth a year, reported that most have a double addiction to alcohol and another drug.[16]

EARLIER ONSET OF USE

The available data also suggests that New Jersey's children are becoming involved with alcohol and drugs at younger ages, sometimes well before they reach high school. For example, more than 34 percent of the students surveyed in 1983 reported that their first use of alcohol occurred before the 7th grade, and nearly 65 percent reported first use before the 9th grade.[17]

Further, more than 25 percent of the students reported first use of marijuana and other illicit drugs before the 9th grade.[18] Moreover, statistics gathered by a New Jersey drug treatment program showed that 67 percent of their young clients first used an addictive substance between the ages of 6-13 years.[19]

THE DEVELOPMENT OF SUBSTANCE ABUSE—MULTIPLE FACTORS RESPONSIBLE

Numerous theories exist regarding the causes of substance abuse. Factors such as genetics, parental and peer influences, psychological make-up and sociological influences have been commonly cited.[20] But, no single factor has been shown to cause substance abuse and it appears that a mix of factors usually comes into play.

The available research does suggest that both parents and peers play strong roles in influencing the substance use habits of young people. For example, studies have found that children tend to model the drinking habits of their parents. One 1978 study reported that the overwhelming majority of children whose parents drink ultimately drank, while the children of abstainers usually were abstainers too.[21]

Studies have also shown that the children of alcoholic parents, particularly an alcoholic father, are more likely to show deviant drinking behavior.[22] A number of studies report too that the children of alcoholics are more at risk of becoming alcoholics.[23]

Three disturbances in family functioning have also been found to be associated with adolescent problem drinking:

- parental deviance, including heavier drinking
- parental disinterest and lack of involvement
- lack of positive parent-child interaction, affection and nurturance[24]

The influence of peers can be a critical factor in a young person's decision of whether or not to use alcohol or drugs. Studies show that prior association with users of a particular substance is the greatest predictor of the individual using that substance.[25] However, a 1980 study found that peer influences are short-lived in comparison with parental influences.[26]

While there is no reliable composite picture of the child who is at risk of substance abuse, studies have identified a number of characteristics which are common among young people who abuse drugs and/or alcohol. They include:

- Perceived distance in the family—findings from studies conducted in schools, treatment centers and correctional institutions all show that the substance abuser saw the family as not being close knit.
- Low self-esteem, with drugs used to avoid feelings of "unsatisfying personal states."
- Low achievement motivation, coupled with an inability to set realistic, attainable goals.
- Tendency to disregard rules, accompanied by a hate for authority figures and a preference for high flexibility.
- Higher need for sensation, manifested by a quest for high levels of excitement (more common among youth who abuse alcohol).
- Lesser involvement with religious institutions and events.[27]

Current research has identified four distinct developmental sequences in adolescent involvement with drugs. These stages include the use of:

1) Beer and/or wine.
2) Hard liquor and/or cigarettes.
3) Marijuana.
4) Other illicit drugs.[28]

One stage—e.g. use of beer—does not necessarily lead to further involvement with a higher stage substance. However, studies have found that many young people who abuse illicit drugs began with a pattern of problem drinking.[29]

Further, drugs that are more prevalent or available in the community tend to be used more frequently, in greater quantities and over longer periods of time.[30] And, increases in the prevalence of the use of a drug have been found to be related to a decrease in the age of onset of use.[31] Clearly, the availability of a drug enhances the likelihood of its abuse.

EARLY ONSET OF USE INCREASES THE LIKELIHOOD OF SUBSTANCE ABUSE

The available research also shows significant reasons to be concerned about early use of chemical substances. For example, starting to drink at an early age and drinking abusively before sound coping mechanisms have been developed increases the likelihood of losing control over drinking habits and developing alcoholism.[32] And, the earlier the onset of use of a drug, the greater the incidence of use of other drugs.[33]

DEVASTATING EFFECTS AND COSTS OF SUBSTANCE ABUSE

Substance abuse bears particularly devastating effects for adolescents because it can interfere with nor-

Princeton Packet, Andrea Kane, Photographer mal physical, emotional, intellectual and social development. Further, physical and emotional damage from substance abuse is believed to occur more quickly in teenagers than in adults.[34]

In addition to impairing the nervous system, substance abuse stalls the maturation process in adolescents by impeding the youth's ability to move through the normal developmental tasks of the adolescent period. Rather than learning mature coping skills to deal with stress and anxiety, adolescents who heavily abuse chemical substances become accustomed to using drugs to avoid the stress altogether.[35] Also this avoidance adds to their inability to deal with the world around them, creating more stress and anxiety. Further, youth who use stimulants or hallucinogens for two to three years can suffer long-term changes in motivation and the ability to experience pleasure through conventional activities.[36]

Substance abuse is particularly risky for adolescents because their physical, psychological and experiential immaturity increases their vulnerability to addiction. In fact, substance abuse may become part of a vicious cycle for youth: the abuse impairs skill development and, because they do not have the coping skills and personality strengths that come with maturity, they are more likely to remain fixed in abusive patterns.[37]

Substance abuse also adversely affects the educational process. The adolescent who is using or dealing drugs often disrupts the school environment to the detriment of other students, and requires administrative intervention which strains the resources of the school. Further, because substance abuse impairs the student's ability to learn, (s)he may leave school without the basic skills for self-support.[38]

Numerous studies have found, too, that substance abuse is associated with higher drop-out rates, absenteeism and criminal activity.[39] In fact, New Jersey Department of Corrections (DOC) officials report that the vast majority of the youth committed to DOC for delinquent acts are substance abusers, and most abuse more than one drug.[40]

In addition to impairing the physical and emotional development of adolescents, substance abuse when carried into adulthood bears heavy costs for the individual and for society as measured in terms of health care problems and costs, crime rates, accidents and lost productivity. For example, data show that:

- Youth aged 18-20 accounted for 32 percent of all alcohol-impaired driver deaths in New Jersey auto accidents for 1980.[41]
- Nationally, alcoholism is the fourth leading cause of death.[42]
- The rate of accidents for substance abusers is four times higher than the rate for non-users.[43]
- At least 40 percent of the nation's industrial fatalities and 47 percent of the industrial injuries can be attributed to alcohol abuse.[44]
- 20 to 50 percent of general hospital beds are occupied by patients with alcohol or drug related problems.[45]
- Nationally, substance abuse costs $70 billion a year in health care costs, days lost from work and lost productivity.[46]
- About 50 percent of the 12,000 state prison inmates surveyed in a nationwide 1979 study had been drinking just prior to the commission of the crime. Over 30 percent had been drinking heavily and nearly 33 percent were under the influence of an illegal substance at the time of the crime.[47]

EARLY INTERVENTION REDIRECTS YOUTH

The devastating and costly effects of substance abuse are not inevitable. As one leading New Jersey expert describes her program:

> "The program assumes that all adolescents wish to meet high expectations but sometimes use methods, such as excess substance use, that actually diminish their ability to meet them. Experience has shown that active monitoring and coordinated efforts on the part of program staff, parents, and school personnel can help adolescents reduce behaviors that are defeating their purposes and improve their abilities to reach their goals."[48]

PARENTAL SUBSTANCE ABUSE

Parental substance abuse also affects hundreds of thousands of New Jersey's children, and many of these children suffer serious long-term physical and emotional damage. For example, maternal alcohol abuse has been identified as responsible for the third leading known congenital disorder associated with mental retardation.[49]

FETAL ALCOHOL SYNDROME AND EFFECTS

In New Jersey, an estimated 135,000 women of childbearing age (15-45 years) have an alcohol abuse problem.[50] Children born to women who have abused alcohol during pregnancy are at high risk of Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Effects (FAE), both of which can serously impair physical and mental development. The recent, limited conservative estimates indicate that nearly 600 infants are born in New Jersey each year with either FAS or FAE symptoms, and the incidence may be as much as 10 times more.[51]

A completely preventable problem, FAS can result in devastating impairments such as facial abnormalities, post-natal growth deficiencies, damage to the nervous system, and abnormalities in the skeletal, cardiac and urogenital systems.[52] Children afflicted with FAE also suffer defects, although they are less pronounced and often less apparent.

In addition to serious physical defects, many of these children experience developmental delays and require programs which offer extra stimulation. Further, while the more severe cases of FAS can be readily recognized, less severe cases are often overlooked and go untreated, contributing to the child's having learning and social difficulties in school.[53]

The costs for treatment and remediation of FAS and FAE are enormous. One recent study found that the costs of lifetime care for infants born with alcohol-related defects in a single year in New York will be at least $155 million.[54]

DRUG-RELATED EFFECTS

Maternal use and abuse of other substances such as prescription drugs, tranquilizers, heroin and methadone have also been found to damage fetal development and cause delivery complications damaging to the infant.[55] The reported effects include: central nervous system defects and other physical abnormalities such as cleft lip and palate; increased infant mortality; and withdrawal symptoms in the infants.[56]

Additionally, there is evidence to suggest that infants born to methadone users are at higher risk of Sudden Infant Death.[57] The full extent and nature of drug-related damage to infants is, however, unknown because there has not been a systematic method for collecting data on the incidence.

EFFECTS ON CHILDREN GROWING UP IN THE CARE OF A SUBSTANCE ABUSER

Children who grow up in the care of a parent who abuses drugs or alcohol are at risk of a host of problems damaging to their physical and emotional development. For example, recent studies show that these children are at higher risk of child abuse.

In fact, a major national study on the problem found that 38 percent of child-abusing parents had histories of drinking problems, and other studies indicate that up to 65 percent of child abuse cases are alcohol-related.[58] Child abuse related to alcohol and drug abuse includes severe physical abuse as well as emotional harm and sexual abuse. One Alateen study, for example, found that 40 percent of the children had been victims of incest.[59]

Further, children in the care of substance abusers manifest a host of other symptoms such as: problems with school work; a greater incidence of emotional disturbance in social and familial relationships; and a higher incidence of depression.[60] Also, numerous studies have found a higher rate of substance abuse among these children as well as higher rates of suicide.[61]

Experts who work with the children of substance abusers report that many experience intense, prolonged stress resultant from the behavior of the substance abuser as well as from disruptions in the overall family situation.[62] Generally, the children are affected in four different areas of their life: self-concept; peer relationships; home life and school life. Additionally, these children are often beset by heavy responsibilities at home, parental inconsistencies; and heavy burdens of guilt for the family situation.[63]

While there has begun to be widespread recognition of the risks to children of substance abusers, the needs of these children often are not identified because neither the non-abusing adults in the family nor other interested adults such as teachers realize the affect of the family situation upon the child. Further, these children often stand alone because they are afraid no one will believe them or are ashamed of their home situations.[64]

Some children are reached by Alateen, a self-help support group for family members of alcoholics and drug addicts. But, since there usually is a long delay between recognizing substance abuse as a familial problem and obtaining remedial action for other family members,[65] children usually do not come to Alateen until long after the family began to be affected by the substance abusing member. Thus, many children live in destructive family situations for extended periods of time without support to cope with the problems at home.

ADDRESSING THE PROBLEM: ADMINISTRATIVE ISSUES

In response to the growing recognition that substance abuse is a serious problem in New Jersey, a variety of prevention and treatment efforts have been developed with federal, state and local funds. However, comprehensive planning has not been developed to assure that a continuum of services are in place to meet the increasing need, and there are significant gaps in preventive as well as treatment services.

NO CLEAR STATEWIDE POLICY

Planning and coordination of services to address the complex problem of substance abuse is impeded by the fact that there is no clear statewide policy to guide the efforts of state and local agencies.[66] This absence of a statewide policy is especially critical in light of the fact that there are a multiplicity of state and local agencies responsible for services for children and families affected by substance abuse.

For example, at the state level at least six different departments have some role in addressing the problem:

- **Department of Corrections (DOC)**—responsible for providing custody and aftercare services for young people adjudicated delinquent, most of whom evidence substance abuse problems.
- **Department of Education (D. of Ed.)**—responsible for developing guidelines for preventive education programs in the public schools.
- **Department of Health (DH)**—through its Division of Narcotic and Drug Abuse Control and Division of Alcoholism, responsible for developing and funding preventive and treatment services.
- **Department of Human Services (DHS)**—through its Division of Youth and Family Services and Division of Mental Health and Hospitals, responsible for providing counseling and residential services for children and families affected by substance abuse problems (provides direct services as well as funding for contracted services)
- **Department of Higher Education (DHE)**—responsible for setting standards for training and certification of professionals such as physicians, nurses, psychologists and teachers who may deal with substance abusers.
- **Department of Law and Public Safety**—responsible for law enforcement efforts and educational programs for highway safety.

Additionally, the courts, particularly through the new Family Part of the Superior Court, must routinely deal with familial problems and juvenile delinquency cases where either the parent or the child has a substance abuse problem. In fact, the recently established county Crisis Intervention Units, linked to the Family Part of the court, must handle crisis situations which may arise as a direct result of substance abuse.

At the local level, there are also a broad mix of public and private agencies that serve children and families who are affected by substance abuse problems. The local public schools represent the largest single group of "agencies" which have consistent contact with children and families.

Other involved local agencies may include:

- Mental health clinics.
- County welfare departments.
- Hospitals and other health care providers.
- Local law enforcement agencies.

The absence of a uniform state policy has fostered considerable inconsistency in how the problem of substance abuse is addressed. For example, some communities and schools view it as a problem to be "treated," while others see it primarily as a matter for law enforcement agencies. Consequently, there are wide variations in the type and extent of services provided for young people at risk.[67]

Even recently enacted state laws reflect an inconsistent approach to the issue. To illustrate: Chapter 85 enacted in 1970 requires that preventive education be required in the public schools.[68] However, this law was followed by P.L. 1981, Chapter 59 which allows school administrators to suspend or expel students who abuse substances, and it does not require the schools to try other less drastic measures before excluding a youth from school.[69] Some schools have instituted programs to keep these youth in school, while others have exercised their discretion to simply punish them by suspension or expulsion.[70]

INSUFFICIENT PLANNING AND COORDINATION OF SERVICES

There have been a number of successful joint projects among the different agencies which address substance abuse and, as well, increasing efforts to develop linkages among the many state and local agencies. However, joint planning has not taken place on an annual basis to set a common strategy and to unify resources in a coordinated approach.

Additionally, planning efforts are to some extent impeded by the fact that reliable data on the prevalence of substance abuse, the characteristics of the youth at risk, and treatment needs are not readily available. The estimates and surveys done to date do not by themselves quantitatively indicate the number and types of services needed. This overall lack of data is an obstacle to efficient resource allocation and programming for services.

Administrative barriers may also complicate the planning process. Within the Department of Health itself, for example, two separate administrative units exist, one to address drug abuse and one to address alcoholism. While there is some merging of activities on behalf of children and youth, each unit carries out separate prevention and treatment efforts. Further, the two units have not developed a common prevention strategy to address youth. There is also some concern that the separation of functions by type of chemical substance may impede the development of a continuum of services for youth who have dual and multiple addictions.

NEW PLANNING EFFORTS

There are several planning processes underway that can improve the overall quality and quantity of preventive and treatment services for substance abuse. For example, through the state Youth Services Commission representatives of different agencies have been brought together in a Health Care Coordinating Committee which has been focusing on substance abuse.

Further, in 1984 the Department of Human Services established a state Human Services Advisory Council with companion councils in all 21 counties. These county councils, charged with the task of making funding allocation recommendations for the Social Services Block Grant funds, can be instrumental in assessing local service needs and increasing the resources for substance abuse programs. Both the state and county councils can, as well, promote improved coordination of social service agencies with those agencies whose primary task is dealing with young people and families affected by substance abuse.

Additionally, improved planning may be spurred by the Citizen Advisory Committees which, under the new Juvenile Code, are required to identify youth needs and develop a plan for provision of services for youth in each county. Recently, a joint request was made by Chief Justice Robert N. Wilentz, Department of Human Services Commissioner George Albanese and Attorney General Irwin Kimmelman that these Citizen Advisory Committees be designated as county Youth Services Commissions linked to the state YSC. These county-level YSCs could be effective in involving both service providers and citizens in assessing and meeting the need for substance abuse programs.

International Youth Organization

Since the new Alcohol Tax legislation, P.L. 1983, Chapter 531, also requires that Citizen Advisory Committees be formed at the county level to assess needs and prepare a county plan for services, it is anticipated that a new emphasis will be placed on the development of alcohol abuse programs at the local level. Under the legislation, youth needs are singled out for priority attention.[71]

There exist, as well, in at least 12 counties Councils on Alcoholism which play a role in the planning of prevention and treatment programs. Some of these councils have been successful already in developing resources for programs serving youth.

While all of these individual planning efforts are quite promising, significant steps have not yet been taken to assure that the different entities will coordinate their activities. Some coordination will be necessary to avoid duplication of effort and a consistent approach in addressing the problems of children and families affected by substance abuse.

PREVENTIVE NEEDS

While treatment programs are needed for both young people and adults who abuse alcohol and/or drugs, they do not substantially reduce the overall incidence of substance abuse. And, if broad-based prevention efforts are not implemented, society will continue to pay a high price for the lost productivity and dependency of those youth whose functioning is impaired by the effects of either their own or their parents' abuse of alcohol and/or drugs.

Many different state and local agencies have recognized the need for preventive programs and some very comprehensive programs have been developed. But, priority for funding has not been placed on preventive services and often promising models have not been implemented because funds were not available.

PREVENTION PROGRAMS ARE COST EFFECTIVE

While it is often difficult to ascertain the actual cost-benefits of prevention programming, a 1984 study of programs in four New Jersey communities strongly suggests that such programs do yield benefits that outweigh costs. The study, which looked at the cost-benefits of four different prevention programs, found that the target communities experienced measurable benefits in terms of reduced vandalism in the community, the provision of volunteer services by community members, and increased school attendance rates.[72] In addition, an educational-intervention program run in the State of Florida has also indicated a favorable cost/benefit effect.[73]

LIMITED PREVENTION EFFORT FOR YOUNG SUBSTANCE ABUSERS

Primary responsibility for prevention programs for young substance abusers has rested with the Division of Narcotic and Drug Abuse Control (DNDAC) and the Division of Alcoholism (DA), each of which has a separate prevention effort. The 1984 prevention budget for DNDAC totaled $1.2 million in federal funds. In 1985 the prevention budget (excluding methadone maintenance programs) will decrease by 9 percent to $1.1 million. Of this fund, $576,923 has been clearly earmarked for projects serving youth such as: $200,000 to local agencies for general prevention projects; $283,000 to 19 drug treatment centers to serve 566 youth; and $93,923 for the Statewide Community Organization Project.[74]

Princeton Packet, Rich Pipeling, Photographer

Until recently, DA was provided with only minimal funding for prevention efforts. For example, in 1984 DA's budget included only $105,000 for prevention efforts administered through 14 Councils on Alcoholism, and an additional $26,725 for preventive activities such as training courses on youth issues, conferences and training seminars.[75]

DA will receive an additional $766,000 in 1985 for educational programs under the provisions of P.L. 1983, Chapter 531. However, even with this new funding, the total funds available to both DNDAC and DA are far from adequate to develop sufficient preventive programs to reach the young people at risk in New Jersey today. And, funding has not been allocated to implement a full range of comprehensive programs that can effectively provide early intervention services for youth in the beginning stages of substance abuse. According to one New Jersey treatment expert:

> Hundreds of thousands of New Jersey parents are worried about the potential link between their adolescent's substance abuse and other problems, and do not see anything they can do about it. In addition, there are thousands of human ser-

vices workers—probation officers, juvenile conference board members, guidance counselors, psychologists, psychiatrists and family therapists—who see young people making poor decisions regarding substance abuse and do not know what to do about it.[76]

FOUR POINT PREVENTION STRATEGY: POSITIVE YOUTH DEVELOPMENT

Generally, there are four different levels of strategies that can be used for prevention of substance abuse among young people. The first level focuses on positive youth development, using programs and activities to reduce dysfunction and alienation in young people, thereby decreasing their vulnerability to substance abuse. This approach emphasizes building strengths through programs such as those which: involve youth in community services; develop youth leadership skills; provide recreational opportunities; and develop vocational skills. A compilation of research and programs for the promotion of positive youth development was drafted in 1983 at Rutger's University.[77]

In New Jersey, the Statewide Community Organization Project (SCOP) has been instrumental in helping communities develop more than 36 model youth development projects. SCOP, housed in the Department of Health, attempts to reduce the prevalence of substance abuse by involving communities in identifying and addressing the needs of young people. Through the SCOP method, teams of community members are trained to plan and implement youth development projects.

An Interagency Youth Development Consortium also has been organized in New Jersey to involve different agencies and community groups in developing prevention efforts. The Consortium, in cooperation with the Association for Children of New Jersey, recently published a resource guide listing programs which communities could utilize for prevention efforts.[78]

EDUCATION

Prevention education is a second approach through which the schools, media and other educational vehicles can be utilized to teach young people about the risks inherent in substance abuse. Generally designed to enable young people to make responsible decisions about the use of alcohol and drugs, preventive education programs also focus on teaching young people alternative coping mechanisms to handle stressful life situations.

Since 1970, public schools have been required by law to provide preventive education. Further, D. of Ed. established a Drug and Alcohol Task Force in 1979 which developed recommendations for prevention and treatment strategies to address student substance abuse. The Task Force's recommendations included suggestions for guidelines for public schools, requirements for teacher training and prevention curricula.[79]

However, many of the Task Force's recommendations have not been funded fully or implemented. As a follow-up report prepared by D. of Ed's Alcohol and Drug Education Committee stated in 1981:

> **The Committee notes with dismay the State's lack of continuous funding for drug and alcohol programs that affect school age children.** The practice of intermittent funding has been demonstrated to be clearly ineffective, and it is, therefore, the Committee's consensus that a permanent funding commitment by the state is absolutely essential. The Committee is greatly concerned that **in recent years the amount of money provided for prevention programs for school age children by the State of New Jersey has not kept pace with the severity of the problem. In fact, the monies appropriated have been negligible.** (emphasis ours)[80]

Further, although the D. of Ed. and Division of Alcoholism cooperatively developed curricula guidelines and models for use by the local public schools, many school districts have not implemented the necessary preventive education programs. It has been reported that the quality of the available programs varies greatly, and, some schools have no preventive education at all.[81] The local variations in curricula used for preventive education are of concern in that studies have shown that inadequate preventive education programs may actually lead to an increase in the incidence of substance abuse.[82] One-shot preventive education approaches have also been found to be counter-productive.[83]

In 1985, substantial funding will be made available for preventive education activities and this may result in expanding current prevention efforts. Through the Alcohol Education, Rehabilitation and Enforcement Fund established under the new Alcohol Tax law, $766,000 is being earmarked for preventive education. Mandated plans include utilizing these funds for in-service training for teachers, school-based intervention programs for students, and employee assistance.[84]

EDUCATE ADULTS

While they have not yet been significantly developed in New Jersey, education programs for parents and other adults who have regular contact with children are also an important component of a comprehensive prevention strategy. Through preventive education, adults can be taught how to identify and deal with children who either are at risk of substance abuse or involved with substance abuse.

EARLY IDENTIFICATION AND INTERVENTION

The fourth general prevention measure is to identify young people when they first begin abusing substances and intervene before the problem has become a set pattern. Prevention programs in this category focus on reaching the youth while the problem is still relatively easy to correct, and they generally include services such as: counseling; peer group interactions; and joint counseling with the youth and his/her parents.

Comprehensive preventive programs have not been widely implemented in New Jersey. However, some school districts have established programs which may serve as models for other communities. For example, the Manchester school district in Ocean County began a program four years ago in cooperation with the National Council on Alcoholism of Ocean County (NCA).

The Manchester program includes: education and training for teachers; student education; student assistance using counseling, support groups, and referrals for treatment; and employee assistance. The student assistance component was initially run by trained staff who were not from the schools, and now school faculty members have been trained by NCA to move into these roles. Plans are now underway to make available similar services in 86 schools in Ocean County with funding from the Alcohol Tax.[85] Union Township also has initiated a program with services such as those provided by the Manchester school district.[86] The River Dell Regional High School District has moved one step further and has combined an adolescent suicide prevention program with its comprehensive prevention program.[87]

PREVENTION PROGRAMS NEEDED FOR CHILDREN OF ALCOHOLICS

Preventive services are needed as well to stem the harm to the hundreds of thousands of children at risk because of parental or even sibling substance abuse. For example, much can be done through public education to raise awareness of how parental substance abuse can contribute to family dysfunction and result in grave emotional and physical damage to children.

Further, parents and other adults who deal with children can be made aware of the need for preventive services to counteract the impact of a very troubled home situation. Currently, the needs of these children often go unrecognized because adults do not realize that the child is being damaged. Some harm to these children could be mitigated if adults were taught to identify the trouble signs and offer assistance in a non-threatening, non-stigmatizing manner.[88]

To date, little emphasis has been placed on developing services for this group of children. Effective approaches, which can be provided through schools and community agencies, include peer support groups such as the Alateen model and counseling.

One relatively new program which might serve as a model, is that provided for children of alcoholics and substance abusers by the Center for Industrial Resources Chemical Dependency Unit of the Community Mental Health Center of Rutger's Medical School. Using a multi-faceted approach, this program is being offered as a comprehensive package for Middlesex and Hunterdon Counties. Components include: training in the identification and referrals of children of alcoholics for school personnel; training for mental health professionals in working with this population; and treatment offered directly to children of alcoholics by the Center's staff. Treatment is based on the concept that alcoholism is a family problem and services are offered for children as well as parents who are living with substance abusing or recovering family members. Group programs are conducted with specific ages, (ages 5-9, 10-12, 13-17, and parents) focusing on the unique requirements of each group, as well as family therapy where necessary.[89]

PREVENTION OF FETAL ALCOHOL SYNDROME

Preventive efforts are necessary too in order to reduce the incidence of Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE). In New Jersey, substantial work on identifying prevention needs has been done by a Task Force on Fetal Alcohol Syndrome established by the Division of Alcoholism (DA). The Task Force has found that two basic approaches are required to prevent FAS/FAE:

1) Education of all citizens about fetal alcohol risk.
2) Identification, intervention and treatment of alcohol abusing women by trained professionals, preferably before pregnancy.[90]

DA has prepared a plan which calls for a multi-faceted approach to preventing FAS, using a network of all those who have an interest in or provide services for women and their families. According to DA, public education is a key prevention method since "research has shown that women want information on all risk factors during pregnancy and are willing to modify their behaviors." The comprehensive prevention strategy developed by DA would also include training of health care professionals to recognize women at risk, and to identify and treat infants born with FAS/FAE.[91] Through DA, technical assistance can be provided for the establishment of a statewide prevention effort.

GENERAL PREVENTION: TRAINING PROFESSIONALS

Professionals in fields such as health care, education, social services and law enforcement are in key positions to either initiate or provide primary as well as secondary prevention services. However, in order to do so, they must be trained to identify the problem of substance abuse and they must know basic interventions. But often substance abuse issues are either overlooked completely in professional training programs or given very minimal coverage.

For example: although physicians have a great deal of contact with substance abusers, since they often experience medical problems, many physicians do not receive adequate training on the topic. In fact, a 1978 study of 117 medical schools found that almost half of the schools did not provide instruction on substance abuse issues for their residents.[92] This lack of training may well contribute to a failure to diagnose the problem and provide appropriate, early intervention.

As one expert noted, "failure to treat seems to be determined more by a failure to diagnose."[93] And, despite the fact that alcoholism is the fourth leading cause of death in the United States, "the prevalence of alcoholism as seen in general office practice is usually estimated as exceedingly low,"[94] which points to a failure to identify the problem.

Failure to properly diagnose is very dangerous in light of the fact that physicians may prescribe medications that are alcohol interactive or which may interact harmfully with another illicit substance the patient has been taking. For example, valium has been one of the most widely prescribed drugs in the world, and can interact with alcohol. Once given to alcoholics, these drugs are frequently taken in conjunction with alcohol.[95]

The relatively low emphasis placed on training of physicians is perhaps most evidenced by the fact that knowledge of substance abuse issues is not required for licensing. In fact, the national board examinations administered to physicians do not have any questions on either alcohol or drug abuse.[96]

Just as physicians should be able to identify substance abuse, so should other professionals who work with children and families such as school nurses, psychologists, social workers and juvenile officers. While awareness of the need for such training is increasing, it still is generally given only slight emphasis in professional curricula.[97]

New Jersey, however, does show a progressive stance in the area of training of professionals. One 1981 national study, for example, cited Rutgers University, which offers a doctorate in psychology with a special concentration on alcoholism.[98] Further, Rutgers has also pioneered an innovative Center for Alcohol Studies which provides comprehensive training programs for professionals from many different fields in the identification and treatment of substance abuse.

TREATMENT ISSUES

Treatment for youth must be geared not only to the basic issues of substance abuse but must also address the unique needs of adolescents. Generally, residential treatment services include these program elements:

- Counseling, both on the individual and group levels, in order to deal with any deeply set pathologies, foster interaction with others, and develop more effective coping strategies for day to day living.
- Education to provide the adolescent with the necessary skills to earn a living.
- Recreation to provide constructive outlets for energy.
- Development of a non-substance abusing peer group—This is essential if continued abstinence is to be maintained, particularly since the adolescent's group of friends in the community usually was involved in fostering the drug use. Peer support and a social network of other non-users is also necessary to aid in the resolution of day to day problems.
- Intervention for problems in the family, to address those familial problems related to the youth's substance abuse. Studies have shown that treatment programs which include intervention with the family show a lower rate of client recidivism.[99]

However, despite the need for programs tailored to the specific needs of adolescents, few treatment services exist for youths who are substance abusers or heavily addicted. Further, a full continuum of services ranging from community based out-patient programs to residential care is not available nor are there a range of programs for youths with dual and multiple addictions.

INSUFFICIENT RESIDENTIAL PROGRAMS

Although there are an estimated 36,000 teenage alcoholics in New Jersey,[100] there are only three facilities with a total of 111 beds providing residential treatment for adolescent alcohol abuse—New Hope, Beacon Hall and Monmouth Chemical Dependency Center. Other facilities which primarily serve adults will accept adolescents, but their programs are not tailored to the unique needs of youth. In 1983, a total of 487 youth were admitted to hospitals or residential treatment centers for alcohol abuse.

Residential treatment resources are even scarcer for those youth whose primary problem is drug abuse. No state operated facilities exist for treatment, although state supported facilities for adults will accept some adolescents. There are a few private hospitals with special programs for adolescents, but these facilities are quite expensive and often the fees are not covered by private medical insurance. Limited data on admissions to public and private New Jersey facilities indicate that about 158 youth under the age of 18 were treated in residential drug treatment centers.[101]

RELIANCE ON OUT-OF-STATE FACILITIES

In the absence of sufficient programs in New Jersey, many youths are sent to out-of-state facilities. In 1983 alone, at least 414 youths were treated out-of-state, and almost all of these youths were sent to facilities in Pennsylvania.[102] Data prepared by the Pennsylvania Department of Health show that 27 percent of these youth had been referred by New Jersey legal authorities. Similar statistics were reported in 1981.[103] Nearly half of these youth had a primary problem of alcoholism; the remainder were abusing drugs such as marijuana, amphetamines, cocaine, PCP and sedatives. Over 75 percent of these youth were abusing both drugs and alcohol.[104]

Due to "gaps" in the data collection process it is difficult to ascertain the number of adolescents treated in states other than Pennsylvania. Many youth are sent to treatment facilities in states which do not report the number of New Jersey clients treated[105] (e.g. Hazelden in Minnesota). And the lack of sufficient treatment often makes treatment inaccessible or extremely expensive. Further, the lack of sufficient out-patient treatment programs at the community level may necessitate the use of residential treatment.[106] It is therefore safe to assume that some children who require treatment are not receiving it due to the costs involved or are not receiving treatment which is least intrusive in their lives.

DIMINISHED RECOVERY POTENTIAL

Use of out-of-state residential treatment centers may lead to service gaps which greatly diminish the potential for successful, long-term recovery. First of all, placement in a distant facility makes it difficult to work with the family of the youth, and most experts believe this is an important part of the treatment process.[107]

Additionally, when the youth is placed a long distance from home, (s)he may be denied the contact and support the family would be able to offer. Further, young patients leaving out-of-state facilities may not have access to suitable after-care services when they leave the treatment center.

After-care is almost always required for the substance abuser to maintain the treatment gains made while in a residential facility; in fact, treatment without appropriate after-care has a low probability of success.[108] As one expert noted, "Prevention of relapse is a lifelong struggle and can only become . . . successful when strong post-hospital care services are available."[109] Further, numerous professionals report that those abusers who do not have access to after-care services are far more likely to require additional admissions to residential care.[110]

AFTER-CARE SERVICES NEEDED

However, New Jersey has a paucity of after-care services for youth returning from residential treatment, and many of these youths simply do not receive the necessary services. Further, there are no half-way houses or transitional living facilities specifically for young people who cannot return to their families or original living situations when they leave residential care. Thus, many youths return to the community without the kind of support or living environment they require to assure their continued recovery.

Since some of these young people come from very troubled family situations, they may be eligible for post-release services from the Division of Youth and Family Services (DYFS) which could include the provision of out-of-home placement. It is possible that their after-care needs could be met through the joint provision of services through the Division of Alcoholism and DYFS.

OUTPATIENT TREATMENT

Outpatient treatment consists of a variety of services offered through an agency established in the community such as an independent clinic or as an ancillary service of a residential treatment facility. There are basically two types of services offered, treatment of the client and/or referral for more extensive residential treatment.

Evaluation of the "needs" of the client determines the type of treatment offered. Clients who are physically addicted, having serious psychological or medical problems and without the support of their family are referred to inpatient residential treatment. Outpatient care is offered as an "aftercare" program in some instances.[111]

Outpatient drug-free treatment is appropriate for clients who display a pattern of abuse consisting of a frequency of use of 2 to 3 times weekly and of a duration of less than 18 months. In addition, clients should have a limited history of anti-social behavior and the support of the nuclear family, while still being enrolled in school or employed.[112]

In cases of clients who are more dysfunctional, outpatient day-care services are appropriate. Clients have a more extensive history of abuse, (a frequency of use up to 4 times weekly and for a period not to exceed 24 months). Their history of anti-social behavior should be brief (up to 3 years) and some family support should be available. In addition, the client's involvement with school or employment may be minimal.[113]

The role of the family is very important in outpatient treatment because the family provides the basic environment of the client. Cooperation of school personnel is also important in helping the client recover. Many of the outpatient agencies stress these roles and work with both families and teachers.[114]

INSUFFICIENT OUTPATIENT TREATMENT FACILITIES

Just as there is a shortage of residential treatment facilities and **no** transitional living facilities for youth, there is a shortage of outpatient treatment facilities for youth. One leading New Jersey drug treatment expert stated, "Federal cuts have fostered the closing of approximately ten nonprofit agencies in New Jersey. These cutbacks were the rationale for eliminating 50 percent of the treatment available to dysfunctional marijuana clients . . . In addition, we know that costly inpatient hospitalization is inappropriate for the vast majority of drug users."[115]

In 1983, limited data reports that 394 youth under the age of 18 utilized outpatient services for alcohol abuse in New Jersey facilities.[116] And, approximately 476 utilized outpatient drug treatment services in New Jersey facilities.[117]

MEDICAL INSURANCE COVERAGE FOR SUBSTANCE ABUSE TREATMENT—INCONSISTENT

Conflicting public policies regarding both public and private medical insurance coverage for treatment of substance abuse are indicative of the confusion and lack of consistency in dealing with drug and alcohol abuse. Although alcoholism was accepted as a "disease" by the American Medical Association in 1956, it was not until 1977 that private medical coverage became mandatory in New Jersey.[118] However, Medicaid coverage has not been provided and it has only been through select demonstration projects that alcoholism treatment is available to Medicaid clients in New Jersey.[119]

Recent passage of P.L. 1984, Chapter 86 has expanded Medicaid coverage for drug abusers under the age of 21 who are Medicaid eligible. Although legislation has been introduced to mandate private insurance coverage for drug abuse treatment, currently coverage is not mandated.

Therefore, drug abuse treatment is only available for Medicaid eligible youth, while for the most part alcoholism treatment is only available for privately insured youth.

NEW PROGRAM DEVELOPMENT FOR ADOLESCENTS—COMPREHENSIVE PLANNING NEEDED

While it is clear that specific additional services are needed for adolescents in New Jersey, comprehensive planning has not taken place to determine where **and** how these programs should be provided. Nor has a determination been made as to how extensive a role the state should take in developing and providing the services.

Many experts agree that, while fiscal support from the state is necessary to assure the provision of adequate services, the state's role should be that of a catalyst for the planning and provision of services by local agencies rather than a direct service provider. As the Director of one of the nation's foremost chemical dependency treatment centers for youth stated:

> "Ideally the State should not focus on being the actual provider of services. Rather, it should assess the number and types of services available, and through evaluation, determine the service needs areas. Special funds could then be made available for the implementation of needed programs and services, either through direct reimbursement, County funding or through special grants. The State should also be involved in program licensing, prevention services, and possibly continuing education."[130]

However, the current planning system used for program development is not structured to catalyze local, public and private agencies to develop and operate specific needed services for the state's young people. Nor are current planning efforts sufficiently comprehensive to assure that existing resources are efficiently utilized and that maximum cooperation is obtained from the local public and private agencies for the development as well as operation of needed services.

The provision of major new funding for services could, at first glance, appear to be the obvious solution to the urgent need for additional treatment programs. However, unless funding is preceded by appropriate planning, it is unlikely that the new funds allocated will be effectively applied to bring services to the young people who are most in need of them.

RECOMMENDED ACTIONS

I. STATEWIDE POLICY FOR BROAD-BASED PREVENTION AND TREATMENT

The Governor should initiate a statewide policy for the development of a broad-based, coordinated effort to prevent substance abuse and to assist and treat children, youth and families affected by substance abuse. Prevention and early intervention programs should be given equal priority with treatment services in the development of policy and programs.

II. STATEWIDE MECHANISM FOR COORDINATED PLANNING AND IMPLEMENTATION OF SERVICES

A. An on-going statewide mechanism should be established to coordinate the work of the different state departments and community agencies in planning and implementing prevention, early intervention and treatment services for children and youth affected by their own or parental substance abuse. This mechanism should:

1. **Include in its membership:**
    - The directors of the Divisions of Alcoholism and Narcotic and Drug Abuse Control of the Department of Health.
    - Representatives of the Department of Education units responsible for prevention and early intervention programs in the schools.
    - Representatives of the Divisions of Youth and Family Services, Mental Retardation, and Mental Health and Hospitals of the Department of Human Services.
    - Representatives of these other state government units: the Departments of the Public Advocate, Corrections, Community Affairs, Law and Public Safety and Labor, and the Administrative Office of the Courts.
    - A representative of the state Youth Services Commission.
    - Representatives of community groups and local agencies who work with children and families affected by substance abuse, and experts in the fields of prevention and treatment.
2. **Maintain close linkages with county level planning groups** which specifically address the problem of substance abuse such as the county Councils on Alcoholism, and maintain linkages with other state and county level planning groups which address youth needs.
3. **Function as a special committee** of the new Governor's Commission for Children and Youth with responsibility to prepare recommendations to the Commission on at least an annual basis for state action to improve services for the prevention, early intervention and treatment of substance abuse.

III. STATEWIDE PREVENTION AND EARLY INTERVENTION EFFORTS

A. STATEWIDE PLAN

Through the special committee of the Governor's Commission on Children and Youth, a statewide plan for prevention and early intervention efforts should be developed and modified as needed on an annual basis. This plan should include efforts addressing substance abuse among young people as well as efforts to ameliorate the problems resultant from parental substance abuse, including Fetal Alcohol Syndrome. The plan should also incorporate the additional recommendations for action reported here.

B. ESTABLISHMENT OF A NEW PREVENTION OFFICE

The Department of Health should combine the preventive efforts of the Division of Narcotic and Drug Abuse Control, which are non-methadone maintenance oriented, with the preventive efforts of the Division of Alcoholism. This new office, the Office of Alcohol and Drug Dependency Prevention should:

1. Be a central resource for all state, local, and voluntary agencies which deal with children and their families, functioning as a Clearinghouse and Data Bank.
2. Have as its initial and primary focus, the population under 21 years of age.
3. Develop and implement strategies to focus on the family as a unit.
4. Have written agreements with all state departments and divisions that deal with children, youth and families as well as special contracts with each county.
5. Have designated liaisons with each major state department and county to meet regularly, coordinate, evaluate and provide assistance in preventive efforts.
6. Report to the special Committee of the Governor's Commission for Children and Youth on a regular basis, cooperating with the Committee's statewide prevention efforts.

IV. SCHOOL-BASED EFFORTS

A. UNIFORM GUIDELINES

The Department of Education should ensure that the local school districts adopt and utilize uniform guidelines to provide prevention and early intervention services for:

1. Substance abuse among students.
2. Services for children and youth at risk because of parental or sibling substance abuse.
3. Staff problems related to substance abuse.

B. PREVENTIVE EDUCATION, STUDENT ASSISTANCE AND EMPLOYEE ASSISTANCE

The Department of Education should also ensure that local school districts:

1. **Educate students** grades K-12 on substance abuse, including the effects of parental substance abuse, through implementation of approved curricula which meets already existing state mandates.
2. **Provide student assistance services and constructive intervention** in accordance with the intent of P.L. 1983, Chapter 531, for students who manifest substance abuse related problems affecting performance in the school setting. The local school districts should be required to utilize less drastic alternatives before excluding a youth from school. The program, which should also address the needs of children affected by parental substance abuse, should include:
   - Staff training and development.
   - Educational awareness.
   - Procedures for a system of referrals of youth for intervention and treatment services.
   - Development of support groups for youths who are recovering substance abusers.
   - Development of support groups for children and youth who live with a substance abuser.
   - Programs utilizing peer leadership to educate and assist other students.
3. **Incorporate Substance Abuse Counselors into the school system to implement curricula, provide counseling services, and develop as well as implement programs.** These counselors should be certified by the New Jersey Alcoholism Certification Board and meet appropriate requirements developed by the Department of Education.
4. **Provide an Employee Assistance Program for school personnel** affected by substance abuse. At minimum, the program should include a mechanism for the referral of staff to treatment services. Teacher representative groups should be encouraged to participate in the development of the program.

C. EVALUATION

The Department of Education shall develop and implement criteria for the evaluation of the quality of these programs to ensure parity of services, regardless of the district in which a student resides.

D. PROGRAM ASSISTANCE

The Department of Education shall offer the Districts program assistance in conjunction with the Department of Health in the development of the programs outlined here for both students and employees when:

1. A District's substance abuse program is deemed inadequate by the Department of Education.
2. A District requests aid.

V. TRAINING OF PROFESSIONALS

A. **School personnel:** Training for school administrators and teachers should include education for the identification of substance abusers and the identification of children at risk because of substance abuse within the family situation. Mandatory training should be included in the curriculum for teacher certification. In-service training should be required for those personnel who have already been certified.

B. **Health Care and Mental Health Professionals:** Training in the identification, treatment and effects of substance abuse should be made mandatory for the certification and licensing of health care and mental health professionals.

Professionals licensed to practice in New Jersey should be required to demonstrate competency before licensing. Such professionals should include but not be limited to:

- Physicians.
- Psychiatrists.
- Clinical Psychologists.
- Counseling Psychologists.
- School Psychologists.
- Social Workers.
- School Nurses.
- Pharmacists.
- Registered and Practical Nurses.
- Other professionals in the practice of psychotherapy.

VI. PUBLIC EDUCATION

The Departments of Education, Health and Human Services should be directed to develop a public education program involving local schools, community agencies, community groups and the media in:

A. **Training parents to recognize patterns of substance abuse** in young people, and educating them on intervention.

B. **Informing the public of the incidence and effects of parental substance abuse** on children in their care, and early intervention strategies to protect vulnerable children.

C. **Informing the public of the risk and effects of Fetal Alcohol Syndrome and Fetal Alcohol Effects.**

VII. TREATMENT

A. CONTINUUM OF SERVICES

The special Committee on substance abuse should develop a plan for the development of a continuum of treatment services for youth who are substance abusers. The continuum should be designed to tailor services to the individual needs of the youth and to provide services in the least intrusive and least restrictive manner necessary. The continuum should include programs for youth who are abusing more than one substance and should consist of but not be limited to these types of services:

- Out-patient treatment.
- Out-patient care services.
- Residential care.
- After-care.
- Transitional living facilities.
- Host homes for youth who cannot return from treatment to their own homes.

B. FUNDING

The state should provide a minimum of $10 million for the development of this new continuum of services. According to the Department of Health, $10 million would support the development of sufficient services to reach 3,500 youth over a 30 month period.

C. STUDY EFFECTIVENESS OF HAVING SEPARATE UNITS

The Office of Management and Budget and the Department of Health should be directed by the Governor to conduct individual studies of the effectiveness of the current separation of the Division of Alcoholism and the Division of Narcotic and Drug Abuse Control. These studies should focus on efficient utilization of fiscal resources by each Division, maximization of the state's ability to develop an appropriate continuum of services for youth who are multi-abusers and efficient utilization of funds in order to implement such services.

D. MEDICAL INSURANCE AND MEDICAID COVERAGE

Medical Insurance and Medicaid Coverage for Both Drug Treatment Services and Services for Alcohol Abuse-Related Problems: Private insurance providers should be mandated by law to provide coverage for drug treatment services and Medicaid coverage should be provided for drug treatment services regardless of the age of the client. Further, Medicaid should expand its coverage to include treatment services for alcohol abuse related problems for all those who are Medicaid eligible.

VIII. STATEWIDE PLAN TO ADDRESS FETAL ALCOHOL SYNDROME

The Department of Health should implement a statewide plan for the early identification and treatment of children at risk of Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Effects (FAE). That plan should include:

A. Educating physicians to identify and intervene with pregnant women who are abusing alcohol.

B. Standard criteria for medical evaluation of infants and children suspected of suffering from FAS or FAE.

C. Steps for smooth coordination of medical, developmental, psychosocial, educational and alcoholism treatment services for affected children and parents.

D. Development of a directory of appropriate resources and services for prevention and treatment of FAS/FAE.

E. Maintenance of a data collection system as part of the Special Child Registry to gather data on the incidence of birth defects resultant from maternal alcohol or drug use and abuse.

* * *

To provide a picture of the types of activities and programs needed to address the problem of substance abuse, following is a chart which summarizes the key elements of a comprehensive prevention, identification, early intervention and treatment strategy.

Attachment 5.1

PREVENTION, IDENTIFICATION, EARLY INTERVENTION AND TREATMENT FOR THE EFFECTS OF SUBSTANCE ABUSE UPON CHILDREN AND YOUTH

I. PREVENTION

INFANCY

Education about alcohol and drug effects on the unborn for women and treatment for substance abuse for pregnant women.

Identification of the use of drugs/alcohol by the mother or parents.

Data collection from birth certificates or death certificates of infants.

CHILDHOOD

Education of all children and parents about alcohol and drug abuse.

Positive youth development programming, i.e., problem solving, coping strategies, dealing with emotions.

Development of trusting relationships with appropriate adults outside the immediate family structure as well as normal relationships with other children.

ADOLESCENCE

Includes items listed under Childhood.

Support for a chemical-free lifestyle.

Education for appropriate alcohol/prescription drug usage.

Student Assistance Programs to help divert the development of a problem.

YOUNG ADULTHOOD

Community Programs.

Information through the media.

Student Assistance Programs for college students.

Employee Assistance Programs.

II. IDENTIFICATION

INFANCY

Infant withdrawal from alcohol or other drugs.

Fetal Alcohol Syndrome or Effects.

Drug induced birth defects.

Sudden Infant Death Syndrome.

CHILDHOOD

Identification of children:

- from dysfunctional homes of alcoholics or drug addicts;
- who are victims of physical or sexual abuse;
- with emotional problems;
- having low self-esteem;
- with low achievement motivation;
- with a tendency to disregard rules;
- perceiving a distance within their families;
- who are sensation seekers;
- who exhibit self-destructive behavior;
- who began the use of alcohol, cigarettes or other drugs at an early age.

ADOLESCENCE

Includes items listed under Childhood.

Excessive absenteeism from school.

Involvement with the Juvenile Justice System.

Suspended/Expelled.

Drop-outs.

Teenage Pregnancy.

YOUNG ADULTHOOD

Regular use of drugs or problem and binge drinking.

Multiple and combined use of alcohol and/or drugs.

Motor vehicle offenses, accidents, driving while intoxicated.

Excessive absenteeism from school/work.

Financial difficulties.

Inability to maintain employment.

Involvement with the Criminal Justice System.

III. EARLY INTERVENTION AND TREATMENT

INFANCY

Treatment for the following conditions if present:

- withdrawal from alcohol or drugs to prevent seizures.
- cleft lip or palate.
- feeding difficulties.
- hypothermia and hypoglycemia.
- cardiac abnormalities.
- pulmonary difficulties.

CHILDHOOD

Early intervention and treatment for the following conditions if present:

- developmental delay and learning disabilities.
- remediation or alleviation of handicaps.
- physical and psychological difficulties resultant from physical, emotional, or sexual abuse.
- family problems—e.g., often the non-drinking parent prevents the child from obtaining help.

ADOLESCENCE ADULTHOOD

Treatment Modalities

Out-patient Treatment

1. Referral for appropriate treatment after the child or youth has been identified and is still relatively unharmed.
2. Treatment of the family in conjunction with the youth.
3. Support for non-using behavior through the use of peer groups in school and the community.

Residential Treatment

Detoxification Program

Medically supervised detoxification from the substances abused.

Rehabilitation Program

Specifically designed for youth who abuse or are addicted to mood altering substances. Program should teach a functional lifestyle free from substances. Duration—2 to 6 months, followed by an aftercare program.

Transitional Living Facility

Facility and program for youth who are in need of longer term programs in order to learn a substance free lifestyle or who cannot return home.

Host Homes, Group Homes, Teaching Parents Homes

Extended care in a supportive environment for youth who cannot return home and need a stable living arrangement.

NOTES

1. This definition of abuse was obtained from: Marc A. Schuckit, M.D., *Drug and Alcohol Abuse: A Clinical Guide to Diagnosis and Treatment* (New York: Plenum Medical Book Co., 1979). The substances are those identified in Wayne S. Fisher and Anne C. Paskow, *Drug and Alcohol Abuse Among New Jersey High School Students; Report of the Attorney General's Task Force on Juvenile Drug and Alcohol Use in New Jersey* (Trenton, NJ: 1981).
2. The Alcohol, Narcotic and Drug Abuse Unit of the New Jersey Department of Health has based this estimate on data from the following sources: Wayne S. Fisher, *Drug and Alcohol Use Among New Jersey High School Students 1984* (Trenton, NJ: New Jersey Department of Law and Public Safety, Division of Criminal Justice, 1984); Joanne E. Finley and Timothy Carden, *1982-1984 New Jersey Behavioral Health Services Plan* (Trenton, NJ: New Jersey Department of Health and New Jersey Department of Human Services, 1981); and *Drug Abuse Among New York State's Household Population: Preliminary Report* (New York: New York State Division of Substance Abuse, 1981).
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7. *Ibid.*
8. Fisher and Paskow, *Drug and Alcohol Abuse Among New Jersey High School Students.*
9. Wayne S. Fisher, *Drug and Alcohol Use Among New Jersey High School Students 1984* (Trenton, NJ: New Jersey Department of Law and Public Safety, Division of Criminal Justice, 1984).
10. *Ibid.*
11. *Ibid.*
12. *Ibid.*
13. Cherry Lowman, Ph.D., "Facts For Planning—Alcohol and Youth," *Alcohol, Health and Research World*, No. 2 (Winter 1981/1982) and J.E. Donovan and R. Jessor, "Drinking, Problem Drinking, and Illicit Drug Use Among American Adolescents: A Psychosocial Study of a Nationwide Sample," *Final Report to the National Institute on Alcohol Abuse and Alcoholism*, Contract No. ADM 281-75-0026 (Rockville, MD: 1978).
14. "Kids and Booze," *The Princeton Packet*, 11 May 1983. This was a supplement written by Yury Tarnavsky, reporter for *The Princeton Packet*.
15. Fisher, *Drug and Alcohol Abuse Among New Jersey High School Students 1984.*
16. "Kids and Booze," *The Princeton Packet*, 11 May 1983.
17. Fisher, *Drug and Alcohol Abuse Among New Jersey High School Students 1984.*
18. *Ibid.*
19. Barbara Ball, (Director, Adolescent Alcohol and Drug Treatment Inc., Summit, New Jersey), letter, March 23, 1984.
20. Robert B. Millman, M.D. and Elizabeth T. Khuri, M.D., "Adolescence and Substance Abuse," Joyce H. Lowinson, M.D. and Pedro Ruiz, M.D., eds., *Substance Abuse: Clinical Problems and Perspectives* (Baltimore, MD: Williams and Wilkins, 1981).
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THE JUVENILE JUSTICE SYSTEM AND THE FAMILY COURT: DEVELOPING PREVENTIVE SERVICES AND COST EFFECTIVE ALTERNATIVES FOR TROUBLED CHILDREN, YOUTH AND FAMILIES

Annually, over 90,000 delinquency complaints are filed against New Jersey young people, and about 11,000 young people are brought before the Courts on non-criminal matters which often stem from family problems. The new Family Court system provides an opportunity to promote a comprehensive approach to the problems of troubled children, youth and families by utilizing non-judicial interventions wherever possible to divert them from the courts. But, few preventive and community-based programs have been developed to address the needs of these children and families.

Consequently, thousands of young people reach the juvenile justice system and ultimately the courts without ever having received preventive services. Further, many children are needlessly detained or incarcerated in costly, locked facilities because appropriate alternatives have not been developed.

- YOUTH AT RISK
- CRITICAL SERVICE GAPS
- LACK OF PLANNING
- OVER-RELIANCE ON COSTLY INSTITUTIONAL CARE
- SPECIAL PROBLEMS WITH USE OF THE JAMESBURG TRAINING SCHOOL
- QUESTIONABLE ISOLATION PRACTICES
- THE FAMILY COURT AND OTHER PROMISING NEW INITIATIVES
- INSUFFICIENT FUNDING TO SUPPORT NEW EFFORTS

Princeton Packet, Rich Pipeling, Photographer

YOUTH AT RISK

During recent years, arrest and complaint statistics indicate that tens of thousands of New Jersey's young people are showing troubled and troublesome behavior in the community and at home. In many instances, these children and youth evidence complex problems which have been compounded by the failure of the community, the schools and their families to recognize and meet their needs.

The available 1982 data for New Jersey show that 107,320 arrests of young people under the age of 18 were reported,[1] and 91,020 delinquency complaints were filed.[2] Another 11,461 young people were brought before the Courts on noncriminal complaints[3] for matters such as being runaway and incorrigible under the Juvenile in Need of Supervision (JINS) provisions which since have been abolished and replaced by the Juvenile-Family Crisis (JFC) provisions in the new Juvenile Code.[4]

The arrest rate for all types of offenses, including municipal violations, for young people aged 10 through 17 was 104.8 per 1,000 in New Jersey.[5] Arrests for this age group represented 29 percent of all arrests reported statewide in 1982. Total arrests decreased by 8 percent, although a slight increase in the number of arrests for robbery and aggravated assault was reported for this age group. At the same time, reported arrests for adults increased by 9 percent. Only 5 percent of the arrests for the under 18 age group were for violent crimes.[6] There is considerable intercounty variability in overall rates of arrests as well as in rates of arrests for specific categories of offenses. A comparison of counties by high and low rates of arrests shows these ranges in rates.

Table 5.1

A comparison of counties by high and low rates of arrests

Type of Offense	Highest Rate	Lowest Rate
Index offense arrests	58.5—(Ocean)	12.9—(Hunterdon)
All other criminal type arrests	45.3—(Mercer)	15.4—(Hunterdon)
Total delinquent type arrests	94.6—(Ocean)	28.3—(Hunterdon)
Total status type arrests	85.6—(Cape May)	16.5—(Hunterdon)

Arrest statistics do not show an upsurge in criminal behavior among New Jersey's young people, but they do clearly indicate that large numbers of the state's teenagers are being brought into the juvenile justice system at an enormous cost to the state's taxpayers.[7] Further, studies of the JINS youngsters have shown that many of the complaints filed were brought by parents who were turning to the Courts because they were unable to contend with their children's behavioral or emotional problems, and did not have access to needed support services. In fact, often the Courts have been relied upon to handle adolescents who were acting out in response to family problems.[8]

In addition to the arrest data, there are other strong indicators that a substantial proportion of New Jersey's young people are at risk of involvement with the juvenile justice system. For example, 44 percent of the 780,472 children between the ages of 12-17 are estimated to be abusing drugs or alcohol.[9] And, according to Department of Corrections (DOC) officials, the majority of the youths committed to state correctional facilities by the courts evidence substance abuse problems involving a combination of alcohol and drugs.[10]

Further, thousands of the state's young people are experiencing difficulties in school. In 1983 alone, over 10 percent or 84,396 children in grades 5 through 12 (ages 10-17) were suspended from New Jersey's public schools.[11] Many youths leave school without completing their educations, and in the urban areas the dropout rate is estimated to be about 50 percent for high school students.[12]

Also, substantial numbers of young people must contend with familial and economic stresses which place them at risk of becoming troubled or troublesome youth. Over the past decade, divorce rates have risen by nearly 500 percent. At the same time, reported incidents of child abuse have risen dramatically. And, an estimated 400,000 New Jersey children are growing up in poverty.[13]

To compound the problem, there are limited job opportunities for those young people who try to enter the labor market. New Jersey's youth unemployment rate is 20.4 percent, and in major urban areas the rate has been estimated to be as high as 60 percent.[14]

CRITICAL SERVICE GAPS AND SERIOUS FLAWS IN THE SYSTEM OF SERVICES

Thus, there is a pressing need for preventive services for young people, including family counseling, treatment for substance abuse and specialized educational and job training programs. In fact, numerous studies over the past decade have noted the need for such services.

For example, in 1977 the Governor's Adult and Juvenile Justice Advisory Committee (GAJJAC) called for the development of a broad range of community-based services to address the needs of young people before they became enmeshed in the juvenile justice system.[15] This blue ribbon committee, which was established to prepare recommendations for major revisions in the state's criminal justice system, found that such services were required to effectuate reforms in the juvenile justice system.

However, five years after GAJJAC released its recommendations, the Commission on Children's Services found that the needs of troubled young people had been largely overlooked and that little emphasis had been placed on developing preventive services for this population.[16] Further, as documented in **Linking Policy with Need,** the Commission found serious flaws in the existing system of services.[17]

Moreover, in the wake of federal budget cuts, services for troubled youth are actually diminishing. The serious implications of the funding cuts and the consequent shortage of preventive, community-based alternatives were high-lighted in a 1983 report by a special Congressional Committee which stated that "As resources dwindle and confusion grows over who treats troubled youth, youth offenders are facing incarceration rather than a second chance."[18] Further, as one juvenile justice expert told the Congressional Committee, "States will be resorting once more to locking up children in spite of the fact that it is far more expensive both in terms of money and cost to human lives."[19]

This trend has begun to be apparent in New Jersey. In fact, a 1983 study by the Association for Children of New Jersey found that some community-based programs have been forced to close altogether, while others have had to drastically reduce their levels of service. Police, probation officers and even judges advised that there are fewer programs to which they can refer youth who may utlimately face incarceration for want of alternative services.[20]

So, thousands of young people who are experiencing problems with their families* or who are violating the law reach the juvenile justice system without having received preventive services. That system (see attached flow chart and description) may generally be described as having six different levels, each of which is progressively more intrusive in terms of degree of formal authority and nature of restrictions that may be imposed. The general levels are:

1. Police Contact
2. Juvenile-Family Crisis Intervention Unit
3. Court Intake Unit
4. Formal Court Adjudication leading to:
5. Probation or Supervision in a Community Program **or**
6. Incarceration or Placement in a Residential Facility.

Many young people can be diverted from the juvenile justice system **before** they reach the Formal Court Adjudication step. In fact, data suggest that almost half of the New Jersey young people brought into custody by the police are released without referral to court.[21] Some are simply released with no further action, while others are referred to a juvenile officer for counseling or to a community agency.

The newly established Juvenile-Family Crisis Intervention Units, now mandated in every county, can also divert young people from court by providing crisis services and linking the youth and her/his family with a community-based program. These units may work with youth who are experiencing family conflicts as well as with young people charged with delinquent offenses. Since these units just became operational in 1984, data is not available on their diversion practices.

Diversion can also be arranged by the county Court Intake Units which were established in every county following the 1977 recommendation of GAJJAC for their implementation on a statewide basis.[22] These units screen complaints and can recommend a nonjudicial disposition where neither the interests of the community nor the interests of the youth require court adjudication of the matter. The nonjudicial disposition may include referral to a community agency or review by a local Juvenile Conference Committee. The available data suggest that as many as 44 percent of the complaints filed annually are disposed of by the Court Intake staff before they reach the adjudication stage.[23]

But, despite the fact that diversion from the system does occur now at different stages, the full potential for effective diversion has not been realized. For example, there are serious concerns as to whether the diversion that does take place results in anything more than simply postponing the youth's penetration into the system. For, few services are available to provide post-diversion follow-up to help those youth who are clearly headed for trouble.

Further, the fact that a tremendous number of complaints do get filed annually raises questions about the overall extent and effectiveness of diversion at the pre-Court Intake stages. That the Court Intake Units are able to dispose of nearly half of the complaints without court action strongly suggests that many of the youth could have been diverted at an earlier stage if appropriate services were provided. In fact, this was an observation made by GAJJAC in 1977.[24]

New Jersey Department of Human Services

Additionally, surveys of juvenile justice system personnel indicate that many of the complaints that actually are adjudicated could be diverted if suitable community-based services existed for the youth and her/his family. Indeed, following the service reductions that resulted from the federal budget cuts, juvenile justice system staff expressed concern that less diversion would now take place.[25]

In 1977, GAJJAC highlighted the critical need for diversionary services, reporting that additional services were required for effective reform of the juvenile justice system. This Advisory Committee strongly urged that additional services be established, using the Youth Service Bureau model which had been developed in 22 communities to provide a mix of delinquency prevention services. Further, GAJJAC noted that "the majority of troubled youth in New Jersey are denied such services," because fiscal constraints prevented communities from establishing them.[26]

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*Since 1974, New Jersey law has made a distinction between status offenders, (JINS), and youth charged with criminal offenses. Thus, status offenders cannot be placed in secure detention or committed to DOC facilities. However, they still may go through an adjudicatory process which can result in their being placed in a residential facility.

Today, however, there are only 14 Youth Service Bureaus in existence. Many relied on federal funds administered through the State Law Enforcement Planning Agency (SLEPA), and when these funds were reduced neither the state nor the local communities provided alternative funding for them. And, to some extent the Youth Service Bureaus have not been successful in reaching those youth who were most prone to delinquency since they did not all place priority on serving the most troubled youth.[27]

Thus, despite long-standing recognition of the need for diversionary services, neither the state nor local communities have made significant efforts to assure their provision. Further, although there are a myriad of state and local agencies who have responsibility for providing services for youth, they generally have not placed priority on dealing with delinquency-prone youth.

Morever, as both GAJJAC and the Commission on Children's Services found, the services that do exist for youth are not well-coordinated. Existing programs have not been organized into a unified system of services, and agencies do not consistently work together to assure that youths with multiple problems receive the full range of services they require.[28]

In fact, GAJJAC reported that fragmentation of services "is a major obstacle to effective juvenile justice reform."[29] And, the Commission on Children's Services noted that fragmentation of services has resulted in lack of accountability as well as delays in the provision of services, often to the detriment of those young people who most need the services.[30]

Further, there are wide variations in juvenile justice policies as well as availability of services from one county to another.[31] Thus, how a young person is handled may depend more on where she/he lives than on the nature of her/his problem or offense.[32]

LACK OF PLANNING

The deficiencies in the broad system of services have been compounded by inadequate and inconsistent planning at both the state and local levels. Comprehensive planning has not been done to assure that resources are efficiently utilized and targeted to the populations most in need.[33]

Moreover, data collection mechanisms have not been established to provide the type of data necessary for planning efforts. Reliable information simply is not available to assess needs, identify service gaps and track service use as well as expenditures.[34]

OVER-RELIANCE ON COSTLY INSTITUTIONAL CARE

In the absence of a comprehensive, coordinated network of services, unnecessarily restrictive and costly approaches are often used to deal with troubled youth who enter New Jersey's juvenile justice system. This has been identified as a problem at the national level as well, with a special Congressional Committee finding in 1983 that "(t)here is an urgent need to reexamine policies that result in troubled youth being locked up rather than treated."[35] According to information gathered by the Congressional Committee, the costs for custodial care of youth in detention centers and training schools are resulting in a disproportionate emphasis on custodial care at the expense of needed rehabilitative and alternative services.[36] As a result, **troubled youth are not receiving treatment services and some are being "pushed into training schools" because alternatives are not available.[37]**

These national patterns are quite evident in New Jersey. For example, in 1982 alone there were 9,736 admissions to county youth detention centers.[38] There are considerable variations among the state's counties in rates of detention with no clear explanation for the variations.[39]

Moreover, a number of studies have shown that the detention centers are being inappropriately utilized for youth who could be handled in other, less costly and less restrictive programs.[40] In fact, studies have demonstrated that some youths are placed in locked detention at a per child cost as high as $93 per day primarily because they require a temporary out-of-home placement and a noncorrectional placement is not readily available.[41] The experience of Essex County, which reduced its detention center average daily population by 40 percent after establishing alternative programs for troubled children, clearly indicates that the availability of suitable alternatives has a direct effect on detention practices.[42]

The emphasis on institutional care has been a pattern in New Jersey since the mid-1800s and the state has been slow to alter this policy.[43] Thus, despite growing recognition that community-based programs are often more effective and cheaper to provide, the state has not mounted a significant initiative to foster the development of such programs for troubled youth who require intensive services. On an annual basis, the state spends at least $40 million for institutional care of troubled youth under the auspices of the Department of Human Services and the Department of Corrections.[44] No similar commitment has been made to funding community-based services which would, in the long run, have the net effect of reducing the need for institutional beds.

Comprehensive reviews of overall state use of institutional care for young people have not been done to determine just how many of New Jersey's institutionalized youth could be served in other settings. National reviews of the issue have disclosed that institutions are inappropriately utilized on a regular basis because other, more suitable services have not been established for troubled youth. Reviews of the population in New Jersey's correctional institutions show similar patterns.

For example, two prior studies reported that these institutions are sometimes used as a "waste bin" for youth and multiple disabilities.[45] In fact, one recent study found that the majority of the children who are eventually incarcerated are very troubled youngsters who do not require secure custody measures.[46]

Further, few community-based alternatives to incarceration exist for those youth who require post-adjudicatory supervision. Since few mid-range programs exist to achieve the dual purpose of holding a delinquent accountable for her/his behavior and providing rehabilitative services, the courts are often forced to choose between probation and incarceration.[47]

Moreover, DOC officials report that the number of youth committed by the courts to DOC for confinement in correctional facilities is exceeding existing bed space. During the past year, as many as 76 youth a month were held in county detention centers on a post-adjudicatory basis awaiting beds in state correctional facilities. Some were held as long as 30 days, and problems of overcrowding in the detention centers were reported.[48]

Between 1981 and 1982, the number of commitments of youths to DOC increased by 19 percent to 1,136. DOC officials report that for many of these youths, confinement in a traditional correctional setting is neither needed for security purposes nor is it the most effective method of rehabilitating young offenders. Further, according to DOC, in some instances an absence of community resources has led to an inordinate reliance upon correctional commitment for youth who could be handled in noncorrectional programs.[49] **In fact, DOC has advised that on a weekly basis it places youth in training school facilities because there is no room for the youth in alternative community and residential programs.**

To address this problem, DOC has focused on developing alternatives to institutionalization. Since 1981, nine new programs have been established by DOC for young offenders. These programs include innovative day supervision projects as well as small residential programs which combine work experience and educational services. Several of the programs are jointly supported by a mix of state, county and local funds. Some of the programs use local community agencies to meet the needs of the youth.[50]

New Jersey Department of Human Services

Costs of DOC's noncustodial programs, which show results "impressive in that the juveniles are better prepared to return to their home environments," average only $10,000 annually per youth, according to the Office of Legislative Services.[51] A Camden County alternative program, highlighted in a special Congressional report, has shown these results with troubled youth:

- Recidivism rate of less than 20 percent as compared with the national average of 50 percent.
- 55 percent of the youth go back to regular schools or vocational schools, and on to college.
- 80 percent of the youth obtain employment in private sector businesses.[52]

But, despite the demonstrated cost-effectiveness of alternatives to incarceration, current funding patterns require that 75 percent of DOC's $18.8 million budget for juvenile services be spent on maintaining beds in three custodial institutions at an annual cost of $18,000 to $24,000 per bed.[53] **While DOC has demonstrated the capacity to establish noncustodial alternatives, strong state support has not been provided to accelerate the establishment of alternatives** to replace traditional institutional beds.

The dearth of community-based services for troubled young people impacts most harshly upon poor and nonwhite children from impoverished urban areas. Indeed, these youngsters have been found to constitute the majority of the populations in New Jersey's secure detention centers and state correctional facilities.[54]

Further, although DOC has clearly stated that many of the young people committed to the department's care could be served in community-based noncorrectional programs operated by agencies other than DOC, little has been done to replicate DOC's alternative programs. Thus, the state continues to spend a tremendous amount of money to fund institutional beds when it could be using the funds to serve more young people at a cheaper cost in more effective community-based programs.

SPECIAL PROBLEMS WITH USE OF THE JAMESBURG TRAINING SCHOOL

The problems associated with reliance on traditional forms of institutional care are particularly apparent in reviewing the use of the Jamesburg Training School for Boys. This facility, which currently has an operating capacity of 444, is very expensive to operate: annual operating costs total $8 million or $18,090 per bed.[55]

Built in 1866, the facility has never been fully modernized and the plant itself is costly to maintain. In fact, $1.5 million or more than 18 percent of the total facility budget must be spent just for plant and support services, while only 9 percent of the budget is available for direct treatment programs for the youth.[56]

When the ratios of plant/support services costs to total operating budgets are compared for **all** of DOC's adult and juvenile institutions, this training school ranks highest in the percentage consumed by these costs.[57] Further, this facility has many physical deficiencies which would be very costly to correct such as: outdated and inefficient plumbing and electrical systems; inadequate ventilation and lighting in violation of standards; deteriorating exterior and interior surfaces; and numerous other inadequacies which pose fire, safety and health hazards to residents and staff at the facility. In 1979, the Correctional Master Plan reported that an estimated $13.5 million would be required to renovate the training school for use by young offenders and to remedy major deficiencies.[58] The costs of making these renovations would be substantially higher today.

Moreover, the physical design of the facility itself presents costly management problems and is not conducive to involving youth in a rehabilitative program. The facility is composed of units which each house 40 residents; and the units cannot be readily separated into smaller, more manageable groups. Thus, the physical design requires that a sizable number of troubled youths be crowded together in a physical setting which makes it difficult to structure their interactions with each other as well as with staff. It has been documented that the incidence of resident on resident violence and resident on staff aggression is much higher in this training school than DOC's alternative programs which group smaller numbers of youth in settings structured to minimize the potential for disruptive behavior.

The fact that the alternative programs cost an average of $8,000 less per year per youth is in a large part due to the fact that these programs have neither the plant costs nor the behavior management costs associated with operation of the training school. There are other significant benefits which contribute to making the alternative programs more cost-effective than the training school. Because of the smaller program size, it is possible to provide more individualized services for the youth. In many instances, it has been possible to obtain additional resources for services from the local agencies where the programs are located, thus enhancing the overall quality of the programs.

Currently, DOC reports that it could cease using this outdated and expensive to operate training school if alternative programs were available for those youth who can function in an alternative setting. According to DOC, at least 300 of the youth housed at the two training schools for juveniles could be placed in alternative programs. Bed space at the modern training school at Skillman could be utilized for those youth for whom custodial care is most appropriate.

While DOC has gradually been reducing the size of the population at the Jamesburg Training School by developing alternative programs for the youth, the cost of maintaining the institution itself impedes DOC's ability to commit a substantial proportion of its current budget for juveniles to the development of the alternative programs. Thus, in the absence of bridge funding to support the transition, DOC must continue to spend funds to operate the Jamesburg Training School at a per youth cost nearly double that for the alternative programs.

Additional shortcomings of the Jamesburg Training School have been a cause for concern and review during the past year. As discussed in the Mental Health Services section of this report, the training school currently receives a number of seriously disturbed youth for whom it does not have either the physical facilities or services to provide proper care. These youth, many of whom have been hospitalized in psychiatric facilities before their placement at the training school, present severe behavior problems which are exacerbated by the absence of proper services and programs.

While the training school's shortcomings have made the facility increasingly unsuitable for young offenders, sections of the facility may be adaptable for use for other special populations, including nondangerous adult offenders currently housed in overcrowded adult facilities. Making bed space at the training school available for those special populations who do not pose a threat to the community might prove useful in alleviating the overcrowding at some of the adult facilities. The training school might also lend itself to other uses such as transitional and aftercare programs for individuals leaving institutions.

QUESTIONABLE ISOLATION PRACTICES AT JAMESBURG

Further, both the physical and programmatic design used at this training school increase the potential for disruptive behavior among the population as a whole. In the wake of corrections officers' complaints about the incidence of resident aggression and other behavior problems, plans have been made to spend $1.5 million to construct a 16-cell isolation unit which will be used to punish youth who present behavior problems. Construction of this isolation unit, which will initially cost $340,000 annually to operate, was slated to begin in the fall, 1984.

Even though on the national level use of extended isolation to punish youths is not standard practice, it is currently being used at the training school which has a 10-cell unit in operation at the present time. Youths are sentenced to spend as long as 30 days in isolation to punish them for infractions of the institution's rules.[59]

This New Jersey practice is markedly different from that used in other states which have similar youth offender populations. For example, neither New York, Pennsylvania nor Delaware permit use of isolation to punish institutionalized youth. These states do employ locked confinement to control a disruptive youth's behavior, but only for very short periods of time. In Pennsylvania a youth whose behavior becomes violent can be confined for four hours. The confinement can be extended for a maximum of 16 hours in a 48 hour period, but cannot be extended beyond that without a court order. New York's regulations are similar, and rarely is approval given to confine a youth for more than six hours.[60]

Further, New Jersey's current practices violate two different sets of national standards. For example, New Jersey's use of 30 day confinements is against even the rather permissive standards developed by the American Correctional Association which permit confinement for no more than 5 days.[61] The standards published by the U.S. Department of Justice prohibit confinement for more than 24 hours.[62]

Experts state that extended isolation is actually counterproductive since it fosters a build up of rage in the youth. For example, the director of Delaware's Division of Youth Rehabilitation Services who is responsible for youth adjudicated delinquent advised:

> Anyone who pays attention to the literature knows (as many of us learned first by bitter experience) a person, whether juvenile or adult, locked up for long periods of time learn to hate and to nurse their anger. You simply exacerbate the problem.[63]

Moreover, the fact that other states such as New York, Pennsylvania and Delaware have been able to minimize the need for isolation by using staff training and structured programs to reduce the potential for disruptive behavior among incarcerated youth raises serious questions about New Jersey's reliance upon use of extended isolation as a behavior management tool. In fact, the Delaware administrator advised that these "**lockups are the most expensive route and the most futile,**" having a "**tremendous negative impact . . . at tremendous cost to the hapless taxpayer.**" (Emphasis ours.)[64]

In light of these factors, there is a need to thoroughly review New Jersey's current practices concerning use of isolation. Further, the appropriateness of spending $1.5 million to construct an isolation unit on the training school grounds requires careful examination. The costs of construction and on-going operation of the unit would absorb a substantial percentage of the very limited funding currently available for young offenders at a time when there are critical and documented deficiencies in programs which should be corrected.

THE FAMILY COURT AND OTHER PROMISING NEW INITIATIVES

Since 1982, a number of promising new initiatives have been mounted to reform New Jersey's juvenile justice system. A **new Juvenile Code,** based in part on the 1977 GAJJAC recommendations, was developed and became effective January 1, 1984. While the new Code mandates harsher sentences for repetitive and serious offenders, it also is designed to encourage diversion of status offenders and minor delinquents from the system, spur the development of alternatives to incarceration and involve counties in planning services for troubled youth.

And, in conjunction with the new Juvenile Code, legislation was also passed to establish Family Part Court Courts within the Superior Court to replace the traditional Juvenile and Domestic Relations Court.[65] The **new Family Court,** intended to promote a comprehensive approach to addressing family problems, has jurisdiction over family-related legal disputes as well as over delinquency matters. Moreover, the Family Court has been designed to shift the focus from the individual litigant to the family as a whole.[66]

Further, in recognition of the fact that the Juvenile in Need of Supervision (JINS) provisions enacted in 1974 have resulted in stigmatizing troubled children without effectively addressing underlying family problems, the JINS provisions have been eliminated from the new Code. Under the Code, the JINS provisions have been replaced by **Juvenile-Family Crisis (JFC) provisions** which are intended to divert status offenders from the system and to focus services on the family as a whole rather than singling out the child.[67]

Since the overall thrust of the JFC provisions is to divert family and youth problems from the courts through timely provisions of services, the provisions require that extensive efforts be made to utilize non-judicial services to resolve parent-child conflicts. The new Code mandates the **establishment of Juvenile-Family Crisis Intervention Units** providing 24-hour coverage in every county. The role of these new units is to assist families by stabilizing the immediate crisis through short-term counseling and then, if necessary, linking them with community-based organizations for long-term services. If the problems continue despite the provision of appropriate community services, a petition may be filed to bring the family before the Family Court.[68]

The implementation of the mandated crisis intervention services may result in reducing the number of young people brought before the courts on noncriminal complaints related to behavioral and familial problems. Additionally, since the crisis units may handle minor delinquency matters, they may also divert minor offenders from the court.

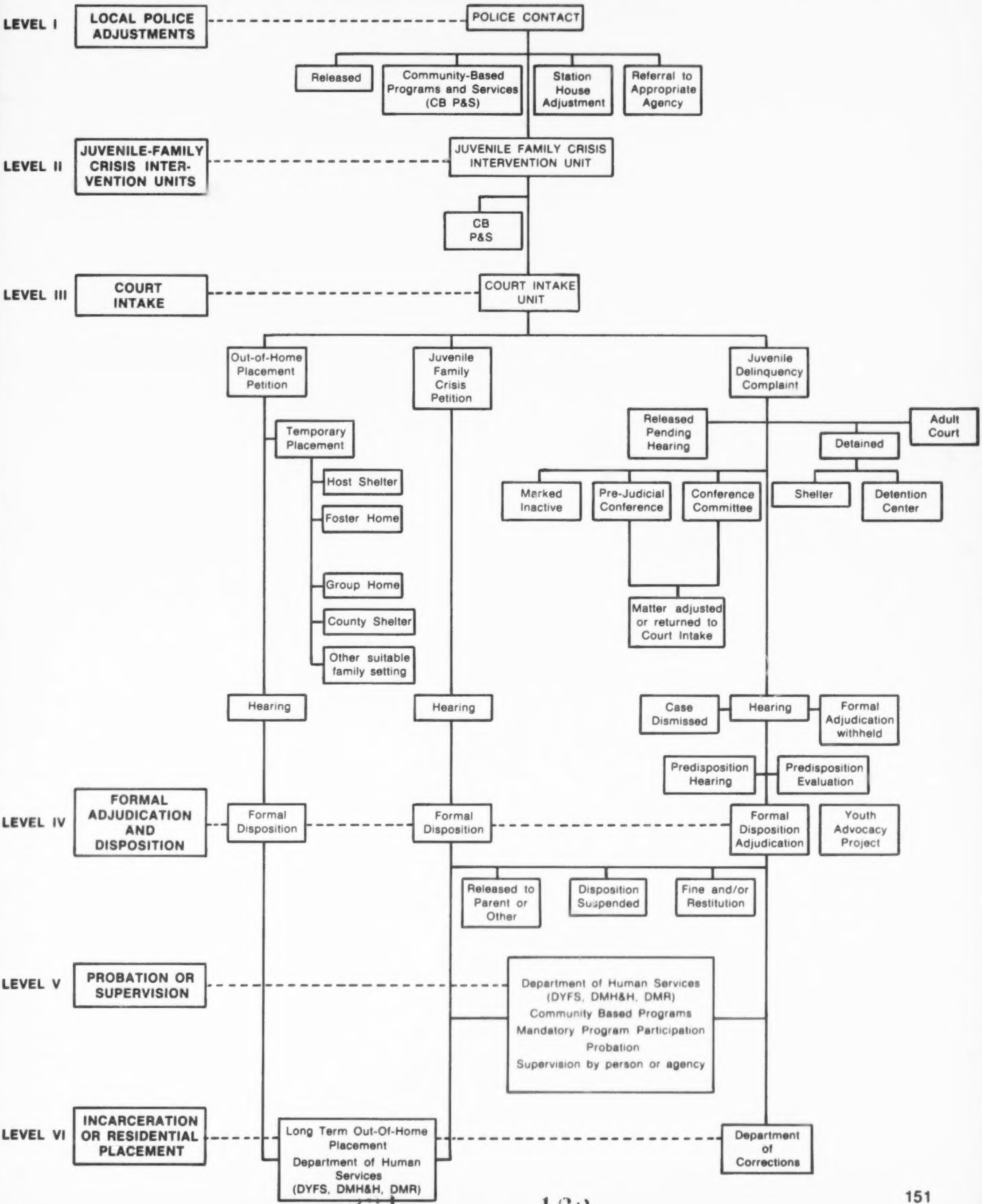
Further, the JFC provisions offer the potential to foster the development of new community-based services for troubled youth and their families. The statute gives the counties the option of providing the crisis intervention services through the Court Intake Unit or establishing them as a separate service. The counties may even opt to have the crisis services provided through one or more private agencies not part of the court system. While some counties have built the units into the court system, others such as Somerset have located them in a community-based agency. And, since these units must operate as a broker for troubled youth and their families, it is anticipated that they will foster greater awareness of and responsiveness to the needs of this population.

The new Juvenile Code also recognizes the need for planning of services and mandates that each county develop a comprehensive plan for youth services every three years. The county plans, already completed for 1984, must be developed by Citizen Advisory Committees appointed by the governing body for the county. The plans must include a needs assessment as well as a resource inventory of youth services in the county. Further, the plans must be designed to meet the unique needs of juveniles and, at the same time, strengthen families and provide alternatives to institutional placement. The statute requires that the plans be submitted to the Commissioner of the Department of Human Services (DHS) for approval, and DHS is required to monitor implemenation of the plans.[69]

While the three-year plans are a step in the right direction, it is generally believed that an annual planning effort is necessary to correct the existing deficiencies in the juvenile justice system. One model that has proven particularly effective in fostering planning and

Attachment 5.2

NEW JERSEY'S JUVENILE JUSTICE SYSTEM: SIX MAJOR LEVELS OF ORGANIZATION AND PROCESS


LEVEL I
LOCAL POLICE ADJUSTMENTS
POLICE CONTACT
Released
Community-Based Programs and Services (CB P&S)
Station House Adjustment
Referral to Appropriate Agency
LEVEL II
JUVENILE-FAMILY CRISIS INTERVENTION UNITS
JUVENILE FAMILY CRISIS INTERVENTION UNIT
CB P&S
LEVEL III
COURT INTAKE
COURT INTAKE UNIT
Out-of-Home Placement Petition
Juvenile Family Crisis Petition
Juvenile Delinquency Complaint
Temporary Placement
Host Shelter
Foster Home
Group Home
County Shelter
Other suitable family setting
Released Pending Hearing
Adult Court
Detained
Marked Inactive
Pre-Judicial Conference
Conference Committee
Shelter
Detention Center
Matter adjusted or returned to Court Intake
Hearing
Hearing
Case Dismissed
Hearing
Formal Adjudication withheld
Predisposition Hearing
Predisposition Evaluation
LEVEL IV
FORMAL ADJUDICATION AND DISPOSITION
Formal Disposition
Formal Disposition
Formal Disposition Adjudication
Youth Advocacy Project
Released to Parent or Other
Disposition Suspended
Fine and/or Restitution
LEVEL V
PROBATION OR SUPERVISION
Department of Human Services (DYFS, DMH&H, DMR)
Community Based Programs
Mandatory Program Participation
Probation
Supervision by person or agency
LEVEL VI
INCARCERATION OR RESIDENTIAL PLACEMENT
Long Term Out-Of-Home Placement
Department of Human Services (DYFS, DMH&H, DMR)
Department of Corrections

coordination of services at the county level is the **Youth Services Commission (YSC)** approach. Piloted in Burlington, Middlesex and Somerset counties since 1982 with start-up funding from SLEPA, the YSCs have involved a diverse mix of public officials, service providers and citizens in assessing youth needs and developing community-based programs to meet them.[70]

The three county YSCs have also been instrumental in improving coordination among youth-serving agencies. Further, they have served as a voice for troubled youth, fostering greater public awareness of youth needs and building public support for new programs.[71] In two of the counties, the YSCs have full-time staff to provide on-going support for the group's work.[72] Through the county YSCs, municipal YSCs have also been developed to work at the local level.

Recently, each county was asked to voluntarily adapt its Citizen Advisory Committee to the YSC model. This request was jointly made by the Chief Justice of the Supreme Court, the Commissioner of DHS and the Attorney General in recognition of the potential the YSC model has for stimulating on-going planning and coordination efforts at the local level.[73] To facilitate the transition, members of the existing county YSCs are providing training for the other counties.

Major coordination efforts have also been initiated at the state level. **In 1982, a state Youth Services Commission was established by cooperative agreement under the auspices of the Administrative Office of the Courts (AOC).** Jointly chaired by the Chief Justice of the Supreme Court, Robert N. Wilentz, and Attorney General Irwin Kimmelman, the State YSC has been bringing representatives of youth-serving state departments together to solve interagency and systemic problems which impede the provision of services for troubled youth. Housed in the AOC, the state YSC has served to focus attention on pressing juvenile justice issues and critical services gaps.

In fact, the state YSC was instrumental this year in helping DOC obtain federal funds to establish a **special Youth Advocacy Project** to develop alternatives to incarceration for youth in seven New Jersey counties. Now in the start-up phase, this project is focusing on those counties which make limited use of alternative dispositions. Project staff will work with local agencies to create post-disposition teams in each of the target counties. These teams will review the cases of youth committed by the courts to DOC, and will recommend alternative dispositions for those youth who do not require confinement in a correctional facility. It is anticipated that the team process, successfully piloted last year in three counties, will lead to the cooperative development of noncorrectional alternative services for many troubled youth. Based upon its experiences in the pilot counties, DOC also anticipates that the project will foster coordination among youth-serving agencies and free additional resources for community-based programs.[74]

Concurrently, the Probation Services Division of the AOC has initiated a diverse range of projects to improve the quality of community-based services for youth on probation. The Division's efforts have focused on building better linkages with other agencies such as mental health programs and job training projects so that young probationers will have greater access to needed services.

For example, in Burlington County, the PATH project has been implemented in cooperation with Drenk Memorial Guidance Clinic to provide out-patient treatment for substance abusing youth and their families. In Mercer County, a comprehensive day program is being provided for delinquent and pre-delinquent youth. Probationfields, a special day treatment program using an intergovernmental network of resources has been established in Passaic County for probationers and plans are under way to establish an "Alternative Grammar School" for young Passaic probationers. Also, in Monmouth County probation staff are working with the county mental health board and local hospitals to develop a special treatment center for juvenile sex offenders.

The Probation Services Division has, as well, been working with a statewide Juvenile Probation Task Force to improve the planning and provision of services for juvenile offenders. The Task Force, which includes representatives from all 21 counties, provides input for policy development, identifies program needs and is involved in program development.

Further, **a Juvenile Delinquency Disposition Commission has been established to assess the impact of the new Juvenile Code** and to gather data on dispositions for youth adjudicated delinquent. The data being compiled by this Commission will include information on the characteristics and needs of the youth, and it will be available to identify gaps in services and to review the effectiveness of different programs for troubled youth.

INSUFFICIENT FUNDING TO SUPPORT NEW EFFORTS

All of the current developments offer the potential to improve the quality and quantity of services for troubled youth. And, the new Juvenile Code reflects an underlying intent to provide preventive and remedial services for young people in the least intrusive and

least restrictive manner necessary to protect the public safety.

But, while the new Code was intended to divert young people from the court as well as foster the development of community-based alternatives, sufficient funding has not been appropriated to support such efforts. The statute provided for a **one-time state allocation** of $225,000 to be divided among the 21 counties for youth services planning, and an additional one-time allocation of $225,000 for the establishment of crisis intervention units.[75] The counties are not assured of any additional state funding to support the crisis intervention units in future years. At an annual allocation of $225,000 from the State, the average share to the individual county is less than $11,000.[76] This is not sufficient to cover the salary of even one crisis intervention worker.

Some of the initial start-up costs for the Family Court services were funded this year by the Department of Human Services (DHS) through a $1.5 million allocation of social services block grant money which was distributed among the counties according to the DHS formula. However, the counties are not assured of future allocations from DHS. Nor have the counties been provided with any new funds specifically for developing alternatives to incarceration such as those spelled out in the new Juvenile Code or for developing alternatives to secure detention.

Further, since existing community agencies have not consistently given high priority to dealing with those youths who are most at risk of involvement with the juvenile justice system, it is doubtful that these agencies will readily shift their priorities to develop the services called for by the new Juvenile Code. There is also grave concern that even the new resources made available to implement the provisions of the code may not be targeted to the development of programs for delinquent youth. There is a current tendency to champion the nondelinquent youth, and, at the same time, justify providing fewer resources for delinquents by categorizing them as being "deserving of their fates."

Thus, regardless of the intent of the new Juvenile Code, little substantive change will take place in the state's juvenile justice system unless implementation of the Code is accompanied by careful targeting of resources to the populations most at risk. Moreover, unless sufficient resources are provided, the required diversionary and remedial services cannot be provided for troubled youth and their families.

Attachment 5.3

COMPONENTS OF THE JUVENILE JUSTICE SYSTEM

New Jersey's Code of Juvenile Justice

New Jersey's present juvenile code was enacted on July 23, 1982 and became effective January 1, 1984. Five laws comprise the new code:

- **PL 1982, Chapter 77** concerns juvenile proceedings and jurisdiction. Young people under 18 years of age enter the juvenile justice system because they are experiencing problems with their families—Juvenile-Family in Crisis—and/or are violating the law—delinquency. The main purpose of the act is to preserve the unity of the family whenever possible and to provide for the care, protection and wholesome mental and physical development of juveniles coming within the provisions of this act.
- **PL 1982, Chapter 78** abolished the juvenile and domestic relations court and established a family court which has jurisdiction to hear and determine all cases where it is charged that a juvenile has committed an act of delinquency or in all matters relating to Juvenile Family-in-Crisis cases, and the jurisdiction of the court shall extend over the juvenile, his parents or guardian or a family member found to be contributing to the family crisis.
- **PL 1982, Chapter 79** is an act concerning the disclosure of information on juveniles charged as a delinquent or found to be part of a Juvenile-Family Crisis and allowing the public disclosure of information on juveniles adjudicated delinquent.
- **PL 1982, Chapter 80** provides for the establishment of Family Crisis Intervention Units in all counties.
- **PL 1982, Chapter 81** directs the establishment of Family and Juvenile Court Intake services and authorizes the appointment of Juvenile Conference Committees.

Levels of the System

Police Contact

Generally, a youth's first contact with the system is through the police who may investigate a report of a family crisis or a crime or actually apprehend a youth on the street. The responding police officer makes the initial decision regarding the case. The matter may be dropped by the police; resolved at the station house; referred to an appropriate agency, i.e., child abuse referral to DYFS; or referred to the Crisis Intervention Unit (CIU) or Court Intake.

Juvenile-Family Crisis Intervention Unit

This unit has been established in each county to provide a continuous 24-hour on-call service designed to attend and stabilize juvenile-family crises. Referrals come directly to the unit from schools, parents and other interested parties as well as from the police.

The CIU tries to resolve the crisis through a family agreement and utilization of appropriate community services; but if the crisis cannot be resolved, and therefore divert the case from the formal court process, the CIU will file a Juvenile-Family Crisis (JFC) petition with the **Court Intake Unit.** And, if no alternative living arrangement is possible during the intervention process, an out-of-home placement (OHP) petition may also be filed.

Court Intake Unit

The Court Intake Unit receives all JFC petitions and delinquency complaints. The unit then reviews the petition or complaint to determine whether the matter can be diverted from the court by: simple dismissal of the petition/complaint; or diversion to the CIU, Juvenile Conference Committee or other community program. If court action is recommended and the petition/complaint is filed, the youth may be released pending the court hearing or placed in the detention center or a shelter. The Court Intake Unit must approve any admissions of youth to the county detention center or the shelter.

Detention and Shelter

Detention and shelter care mean the temporary care of juveniles in county facilities pending court disposition. The locked detention facilities are restricted for juveniles charged with a delinquency complaint who have a demonstrated record of recent willful failure to appear in court, or those youth deemed to pose a threat to the physical safety of persons or property of the community.

The nonsecure shelter facilities may be utilized by Court Intake for other delinquents and those juveniles who are awaiting a juvenile family crisis disposition where an out-of-home placement petition has been filed.

The detention decision is subject to periodic court review:

- An initial detention hearing must be held no later than the morning following the juvenile's placement.
- A second detention hearing must be held within two court days if the juvenile was not represented by counsel at the initial hearing.
- A third detention review hearing must be held within 14 court days of the last hearing and a subsequent detention review hearing must be held at intervals not to exceed 21 court days.

Family Court Hearing Process

Juvenile delinquency complaints and juvenile-Family Crisis petitions are heard by the Family Court judge. Each type of complaint (Juvenile-Family Crisis, Out-of-home placement, delinquency) must be heard separately because the judge must consider different factors for each:

Juvenile-Family Crisis (JFC)

The judge will render a JFC disposition requiring appropriate programs or services for the juvenile and/or the family that address the needs of the juvenile and the family in crisis, i.e., release to a parent, relative or other person; referral to the Division of the Department of Human Services—Youth and Family Services (DYFS), Mental Health (DMH&H) or Mental Retardation (DMR); mandatory program participation.

Out-of-home placement (OHP)

The judge will designate an appropriate agency to develop a family-service plan. And, the judge will render a dispositional order embodying the plan, i.e., long-term out-of-home placement.

Delinquency

Adjudication

At the **Adjudicatory hearing,** the judge decides whether, based upon the evidence offered in the hearing, the youth is guilty of the offense(s) with which (s)he is charged, and if an adjudication of delinquency is therefore proper. For youths held in detention, the adjudicatory hearing must be held no later than 30 days from the date of detention unless an extension is granted by the court. If the juvenile is adjudicated delinquent, the court may refer the juvenile for a **predispositonal evaluation** and possibly a predisposition conference will be held to provide knowledgeable input to the court.

Disposition

The judge then renders his/her decision regarding disposition of the case. In determining the appropriate disposition for a juvenile adjudicated delinquent, the law offers the judge a wide range of alternatives, i.e.: see JFC dispositions plus probation, payment of fine or make restitution, placed under the supervision of a person or agency, mandatory community-based programs or services, commitment to the Department of Corrections and other dispositions outlined in PL 1982, Chapter 77, sections 24 and 25. If the judge commits the juvenile to the Department of Corrections, there are **youth advocacy projects** in seven counties established to review these cases and recommend alternative dispositions for those youth who do not require confinement in a correctional facility.

RECOMMENDED ACTIONS

I. STATEWIDE POLICY: MAXIMUM PREVENTION IN LEAST INTRUSIVE MANNER

The Juvenile Justice System and related community support agencies should function as a broad system for "youth in trouble," i.e., youth experiencing family difficulties or conflicts with the law. This system should emphasize maximum prevention and provision of assistance to youth and their families in the least intrusive manner possible.

The broad Juvenile Justice system can be viewed as having six major levels of organization: (1) Local police adjustments, (2) Juvenile-family crisis intervention unit, (3) court intake, (4) formal adjudication and disposition, (5) probation or supervision, and (6) incarceration or residential placement.

All possible attempts must be made to prevent youth from moving to a more intensive/intrusive level in this system regardless of the level of penetration into the system or the extent of prior efforts to assist the youth. The policy of the State of New Jersey should be: **No youth should be placed in a restrictive facility (regardless of auspices) solely because of a lack of appropriate alternative services.**

To implement this policy, the committee recommends new community-based services, developed through better planning using additional state resources.

II. DEVELOP NEW COMMUNITY-BASED SERVICES

Top priority for planning and funding should be given to new and innovative community-based programs and services at the major pre-adjudicatory levels which are specifically designed to prevent the youth's further penetration into the Juvenile Justice system. Special emphasis should be placed on programming for delinquency-prone youth. These services should include: specialized education programs, family counseling, programs geared to individual development, environmental programs, mental health services, job development and training and treatment for substance abuse. These services may also include programs providing for the assessment and treatment of youth charged with sex offenses.

Full implementation of this prevention policy cannot ignore those youth who reach more intrusive levels of this system. Innovative programs, including a network of nonresidential community-based services, must be created to encompass youth from all these levels, including those juveniles who come before the Youth Advocacy Project teams. Further, a delinquent offender should not be precluded from using pre-adjudicatory services.

III. COUNTY AND STATE PLANNING

A. **A county Youth Services Commission should exist in every county to serve as the comprehensive planning mechanism to implement this policy.** In order to effect this, P.L. 1982, Chapter 80, Section 16, should be amended to require that:

1. A Youth Services Commission (YSC) be established in every county to perform this planning function.
2. The YSC membership includes: Freeholder, County Executive/Administrator, Presiding Family Court Judge, Family-Part Case Manager, Prosecutor, Chief Probation Officer, Public Defender, District Office Manager of DYFS, Mental Health/Human Services Administrator, County Superintendent of Schools, Director of Youth Shelter, Director of Detention Facility, Director of the Juvenile-Family Crisis Intervention Unit, President of the Chiefs of Police Association, President of the Juvenile Officers Association, Member of the Private Industry Council, representatives of the state departments of Human Services and Corrections and youth members. The county may choose to appoint additional members including but not limited to representatives of private community-based organizations and volunteer and child advocacy groups such as Juvenile Conference Committees, Child Placement Review Boards and Volunteers in Probation.
3. The Commission be chaired or co-chaired by a Freeholder, County Executive/Administrator or the Presiding Judge of the Family-Part of the Superior Court.
4. State funding be made available at a level of $500,000 annually for the 21 YSCs, with the specific allocation of each county to be determined by category of county and the county share of costs for staffing of the county YSC.
5. Each county YSC be charged with the following responsibilities:
   a. Annually prepare and submit to the Department of Human Services through the County Board of Freeholders a **need-based plan** prioritized according to high-risk population and high-risk geographical areas within the county.
   b. **Coordinate and integrate existing services** for troubled youth noting gaps in service delivery.
   c. **Develop new and innovative programs** to meet the needs in service gap areas.
   d. **Develop an on-going mechanism** that would determine the extent of juvenile offenses and related juvenile problems and determine geographic locations where juveniles are at greatest risk within the county.
   e. **Develop and coordinate the efforts of municipal and regional** Youth Services Commissions within the county.
   f. **Inform the public** of the nature and extent of the problem, availability of services and other juvenile justice issues.
   g. **Advise** the Family-Part Case Management team in its planning effort.
   h. **Participate** with representatives of the Department of Human Services in monitoring the implementation of the Family Court plan.
   i. **Maintain relationships** with county human services advisory councils, county alcohol citizen advisory committees, county mental health boards, etc., in order to maintain coordinated planning for services and to advocate for the needs of this high-risk population before these groups.

B. **A permanent state-level mechanism should exist to address planning and coordination issues related to the state's Juvenile Justice system and to address those issues raised by the county Youth Services Commissions.** The proposed Governor's Commission for Children and Youth (GCCY) should, once it has been established, provide for the on-going facilitation of this mechanism as part of the GCCY's comprehensive planning role. Further, in light of the work already done by the state Youth Services Commission, the state YSC should function as the Juvenile Justice planning mechanism within the context of the GCCY's broad planning effort.

1. **Role**
   The role of the Juvenile Justice planning mechanism should include:
   - **Coordination of activities** between county and state representatives to develop plans for a program utilizing fiscal incentives to encourage the counties to establish county-based alternatives to incarceration for youth adjudicated delinquent for nonviolent offenses, and
   - **Provision of assistance in developing a minimum information system** supported by state funds (in whole or in part) to provide reliable data for the purposes of planning, budgeting, monitoring, program review and assessing the extent to which state priorities are being realized. The information gathered will be of use to all programs serving high-risk youth.
2. **Membership**
   Membership should include high-level staff from each of the participating state departments and the Administrative Office of the Courts as well as representatives of juvenile justice advocacy groups and provider agencies.
3. **Staffing**
   At least one full-time staff person should be provided by the GCCY for the work of the Juvenile Justice planning mechanism.

IV. PROVIDE ADDITIONAL STATE RESOURCES

A. **Through the Department of Human Services, the State should appropriate on an annual basis $6.5 million for use by the counties to develop and implement the new and innovative services for youth planned by the YSCs.** These new funds should not be used to supplant funds for existing programs. Each county should be required to submit for approval to the Department of Human Services an annual plan that has prioritized its share of this funding to maximize service delivery to the county's own high-risk population and high-risk geographic areas. This allocation should not preclude a county from competing for other monies or from pooling resources with other counties to develop programs for a target population. Of these funds:

1. The majority should be allocated among the 21 counties on a per capita basis for the population group aged 10-17 years of age.
2. The remainder should be distributed to those counties exhibiting such high-risk factors as measured by: rates of arrest, excluding status offenses; rates of social and family disruption; number of families with incomes below the poverty level; rates of youth unemployment; and school drop-out rates.

B. **The state should also provide $520,000 annually to establish, under the auspices of the Department of Corrections, Youth Advocacy Projects in all 21 counties.** These projects, modeled after the Youth Advocacy Project initiated by the DOC, should be required to:

1. **Review detention center admissions** on an annual basis to survey the characteristics of the children admitted to these facilities on a pre-adjudicatory basis, and to determine the extent to which the facilities are being used for children who do not require secure confinement. The findings, which shall be reported annually, shall specify the particular alternative services needed for these children.
2. **Develop multidisciplinary teams to review the case of every youth adjudicated delinquent and about to be committed to DOC** to determine, prior to the youth's actual physicial commitment to DOC, whether the dual purposes of protection of the community and rehabilitation of the youth could be more effectively achieved by the provision of alternative services. In each case where the team finds that alternative services are appropriate, the team shall specify what services are needed.

   The findings of the team shall be reported annually and shall include a statement indicating:
   - number of youth reviewed, number for whom alternative services were appropriate,
   - number for whom alternative services were arranged; and
   - number of youths physically committed to DOC.

   The report shall also indicate specific service gaps identified by the team and the team's recommendations for the development of additional alternative services.
3. **Develop individualized services** plans for youths adjudicated delinquent to provide them with necessary rehabilitative services and supervision within the community.
4. **Recommend, based upon the findings of its review, priorities for the development of alternatives** to secure detention and incarceration on an annual basis to its County Youth Services Commission
5. **Cooperate with an evaluation** of the project at year three to be conducted by the state juvenile justice coordinating mechanism.

V. COST-EFFECTIVE ALTERNATIVE PROGRAMS FOR JUVENILES COMMITTED TO THE JAMESBURG TRAINING SCHOOL

In light of the increasing recognition by the DOC that the rehabilitation and education of juvenile offenders can be more effectively accomplished in small, decentralized facilities/programs capable of responding to the individual needs of particular offenders, a strategy for initiating more alternatives for committed youth should be conceived and implemented.

The Department of Corrections should conduct a study of the feasibility of developing more such alternative facilities/programs for all of the youth now being sent to the Training School for Boys at Jamesburg. The findings should be reported to the Governor's Commission for Children and Youth.

This assessment should include:

- Identification of youths who could be served in alternative programs.
- Description of the types of alternative programs which would be required to provide proper supervision and services for the youth.
- An estimate of the resources required to develop alternative programs.
- An estimate of the initial and continuing resources necessary to transfer youths to, and operate these alternative programs.
- A comparison of the costs of the new programs to the existing programs at Jamesburg.
- Plans to interface with other state departments to develop programs geared to positive youth development.
- Plans to allocate a fair proportion of resources to the provision of services and programs for girls adjudicated delinquent.

VI. REVIEW USE OF ISOLATION

Plans for the construction of the proposed isolation unit at the Jamesburg Training School for Boys should be halted until a thorough review of the appropriateness of plans has been conducted. That review should include an assessment of existing practices concerning the use of isolation, consultation with experts from other states regarding the effectiveness of using isolation as well as information on other methods of minimizing disruptive behavior among young offenders; and an evaluation as to the specific physical and programmatic designs that could be utilized at the Jamesburg Training School with a decreased population and/or for alternative programs to deal with disruptive behaviors in a constructive manner.

NOTES

1. New Jersey Department of Law and Public Safety, *Uniform Crime Report—Crime in New Jersey 1982* (Trenton, NJ: 1982).
2. Statistics reported by the New Jersey Administrative Office of the Courts, May, 1984 and based upon the "Monthly Reports of the Clerks of the Juvenile and Domestic Relations Courts to the Administrative Office of the Courts, September, 1982—August, 1983."
3. *Ibid.*
4. N.J. STAT. ANN. 2A:4A-20.
5. New Jersey Department of Law and Public Safety, *Uniform Crime Report, 1982.*
6. *Ibid.* Violent crimes include: murder, forcible rape, robbery and aggravated assault.
7. *Ibid.*
8. Dale Dannefer and Joseph De James, *Juvenile Justice in New Jersey: An Assessment of the New Juvenile Code* (Trenton, NJ: New Jersey Department of Human Services, 1979); Linda J. Wood and Joan Hammond Brame, *Children in Detention and Shelter Care: Surveying the System in New Jersey* (Newark, NJ: Association for Children of New Jersey, 1979); Linda J. Wood and Carl Moore, *Beneath the Labels: Children in Detention and Shelter Care* (Newark, NJ: Association for Children of New Jersey, 1981); and R. Alexandra Larson and Carol Kasabach, *Linking Policy with Need* (Trenton, NJ: New Jersey Commission on Children's Services, 1982).
9. This estimate was provided by the New Jersey Department of Health, Alcohol, Narcotic and Drug Abuse Unit, 1984 and was arrived at through use of these three sources: Wayne Fisher, Ph.D., *Drug and Alcohol Use Among New Jersey High School Students* (Trenton, NJ: New Jersey Department of Law and Public Safety, 1984); New Jersey Department of Health, *1982-1984 New Jersey Behavioral Health Services Plan* (Trenton, NJ: 1982); and New York State Division of Substance Abuse Services, *Drug Use Among New York State's Household Population: Preliminary Report* (September, 1981).
10. Information reported to the Governor's Committee on Children's Services Planning by the New Jersey Department of Corrections, 1984.
11. As reported by the New Jersey Department of Education, Office of Management Information, September 30, 1983.
12. New Jersey School Boards Association, *Final Report on School Finance* (Trenton, NJ: 1981).
13. Larson and Kasabach, *Linking Policy with Need.*
14. This is the estimated rate of unemployment for the first quarter of 1984 as reported by the New Jersey Department of Labor.
15. Governor's Adult and Juvenile Justice Advisory Committee, *Standards and Goals for the New Jersey Criminal Justice System: Final Report* (Trenton, NJ: State Law Enforcement Planning Agency, 1977, hereinafter referred to as: GAJJAC, *Standards & Goals*), pp. 243-259.
16. Larson and Kasabach, *Linking Policy with Need,* chpts. IV-V.
17. *Ibid.*
18. U.S. Congress, House, Select Committee on Children, Youth and Families, *Children, Youth and Families: 1983, A Year-End Report,* 98th Cong., 2d sess. (Washington, DC: U.S. Government Printing Office, 1984), p. 46.
19. *Ibid.*, p. 47.
20. Shirley Geismar, Tricia Fagan and Patricia Deignan, *Through the Safety Net: A Citizens' Report on New Jersey Children and Families in Need* (Newark, NJ: Association for Children of New Jersey, 1983), chpt. 8.
21. Of the total arrests for young people under the age of 18 years, 41.4 percent were handled within the police department and the youth were released without further action. New Jersey Department of Law and Public Safety, *Uniform Crime Report* (1982 data).
22. GAJJAC, *Standards & Goals*, p. 251.
23. New Jersey Administrative Office of the Courts, "Report of the Status of the Calendars for the Month of June, 1981."
24. GAJJAC, *Standards & Goals*, p. 246.
25. Geismar, Fagan and Deignan, *Through the Safety Net,* chpt. 8.
26. GAJJAC, *Standards & Goals*, p. 253.
27. Information provided by the State Law Enforcement Planning Agency.
28. GAJJAC, *Standards & Goals,* Part II, Juvenile Justice System; and Larson and Kasabach, *Linking Policy with Need.*

29. GAJJAC, *Standards & Goals,* p. 323.
30. Larson and Kasabach, *Linking Policy with Need,* chpt. IV.
31. GAJJAC, *Standards & Goals,* Part II, Juvenile Justice System.
32. *Ibid.* See also: National Council on Crime and Delinquency, "Problem Statement: Patterns of Unequal Justice," (1980).
33. Larson and Kasabach, *Linking Policy with Need,* chpt. IV.
34. *Ibid.*
35. U.S. Congress, House, *Children, Youth and Families: 1983, A Year-End Report,* p. 44.
36. *Ibid.* p. 45
37. *Ibid.*
38. New Jersey Department of Corrections, Juvenile and Detention Monitoring Unit, "Statistics on Juveniles in Detention Facilities—1982," memorandum, (Trenton, NJ: 1983).
39. *Ibid.*
40. Two reports found that *the majority* of the children placed in secure detention centers did not require secure detention. See: Robert Kihm, *Report to the Essex County Juvenile Justice Advisory Committee and Department of Corrections: Assessment of Essex County's Pretrial Detention Needs* (Champaign, IL: Community Research Forum, 1980); and *Report to the Passaic County Juvenile Justice Committee and the New Jersey Department of Corrections* (Champaign, IL: Community Research Forum, 1979). See also: National Council on Crime and Delinquency, "Problem Statement: Patterns of Unequal Justice," (1980); Wood and Moore, *Beneath the Labels;* Wood and Brame, *Children in Detention and Shelter Care;* and Atlantic County Criminal Justice Planning Unit, *Capital Needs Study: Atlantic County JINS Shelter/Juvenile Detention Unit* (Atlantic City, NJ: 1978). All of these studies indicate that the majority of the children detained are not charged with violent crimes and that the majority are ultimately released to nonsecure settings.
41. Wood and Brame, *Children in Detention and Shelter Care,* p. 77. This report, based on information gathered in 1977, found that the average cost of detention care statewide was $58.43 per day per child. Total statewide detention care costs were $9 million. Current costs are probably substantially higher.
42. According to information reported by the Essex County Department of Corrections, the average daily population for the county youth house was 101 children during fiscal year 1979-1980. Following a 1980 study of detention practices, the county developed alternatives to detention which included use of group home care in private residential facilities, home detention programs and use of specialized foster homes called "Mentor" homes. For fiscal year 1983-1984, the average daily population for the detention center was 67 children.
43. James Leiby, *Charity and Corrections in New Jersey: A History of State Welfare Institutions* (New Brunswick, NJ: Rutgers University Press, 1967).
44. Budgeted expenditures for 1984 by the New Jersey Department of Human Services for institutional care for children total $25.9 million. This includes $20.4 million allocated to the Division of Youth and Family Services for an average daily population of 912 children, and $5.5 million allocated to the Division of Mental Health and Hospitals for an average daily population of 140 children (these figures do not include the costs of care for children placed in group homes and Teaching Family homes). Budgeted expenditures for the New Jersey Department of Corrections for institutional care of youth at the two state training schools and the medium security unit total $14.2 million for 1984.
45. Committee on Children's Services in New Jersey, "The Report of the Committee on Children's Services in New Jersey to the State Board of Control of the New Jersey Department of Institutions and Agencies," *The Welfare Reporter* XIX, 3 (July, 1968); and Larson and Kasabach, *Linking Policy with Need,* chpt. IV.
46. New Jersey Department of Corrections, testimony before the Commission on Children's Services, March 23, 1981; and Harriet E. Hollander, Floyd Turner and William Stein, *Juveniles in New Jersey Correction Facilities: A Multi-Dimensional Report* (Piscataway, NJ: Rutgers University Medical School, 1981).
47. New Jersey State Assembly, *Report of the Juvenile Justice Task Force Advisory Committee on Indeterminate/Determinate Sentencing* (Trenton, NJ: 1981).
48. New Jersey Department of Corrections, Division of Juvenile Services, Application to the State Law Enforcement Planning Agency for funding to establish a Youth Advocacy Project (dated 1983).
49. *Ibid.*
50. *Ibid.*
51. New Jersey State Legislature, Office of Legislative Services, *Analysis of Department of Corrections,* (Trenton, NJ: 1982).
52. U.S. Congress, House, *Children, Youth and Families: 1983, A Year-End Report,* pp. 123-124.
53. Budgeted expenditures reported by the New Jersey Department of Corrections for 1984.
54. Detailed information on this issue was provided to the Commission on Children's Services by the Department of the Public Advocate. See: Steven Eisdorfer, (Assistant Deputy Public Advocate), testimony before the Commission on Children's Services, September 21, 1981. See also: National Council on Crime and Delinquency, "Problem Statement: Patterns of Unequal Justice," (1980); Wood and Moore, *Beneath the Labels;* and Wood and Brame, *Children in Detention & Shelter Care.*
55. Estimated expenses for FY 1985 as reported in *State of New Jersey Budget, Fiscal Year 1984-1985* (Trenton, NJ: 1984), p. 67.
56. *Ibid.*
57. Derived from an analysis of New Jersey Department of Corrections budget data reported in *State of New Jersey Budget, Fiscal Year 1984-1985.*
58. Vaughn Organization, *Correctional Master Plan, Stage II, Facility Master Plan, Training School for Boys and Girls, Jamesburg* (Trenton, NJ: 1979).
59. New Jersey Department of Corrections, Standards on Inmate Discipline, Limitation on Sanctions 251.5, *Administrative Plan Manual,* Vol. I (Trenton, NJ: October, 1982).
60. Interstate Consortium on Residential Care, "Policies on Locked Isolation Across the Country" (unpublished survey, 1984), and Michael Shields, "N.J. Solitary Confinement Rules Spark Controversy," *Trenton Times,* 16 July 1984.
61. American Correctional Association, *Standards for Juvenile Training Schools,* 2d ed. (College Park, MD: 1983), p. 82, section 2-9312.
62. U.S. Department of Justice, Law Enforcement Assistance Administration, Office of Juvenile Justice and Delinquency Prevention, *Standards for the Administration of Juvenile Justice; Report of the National Advisory Committee for Juvenile Justice and Delinquency Prevention* (Washington, DC: U.S. Government Printing Office, July, 1980), p. 496, item 4.52.
63. Daniel Cox, (Director, Division of Youth Rehabilitation Services, Department of Services for Children, Youth and Their Families, State of Delaware), letter to Interstate Consortium on Residential Care, July 20, 1984.
64. *Ibid.*
65. N.J. STAT. ANN. 2A:4-3a to -3e.
66. New Jersey Administrative Office of the Courts, *Report*

of the State Family Court Committee to the June 24, 1983 Judicial Conference (Trenton, NJ: 1983).

67. N.J. STAT. ANN. 2A:4A-76.
68. *Ibid.*
69. *Ibid.*
70. As documented in the minutes of the 1982, 1983 and 1984 meetings of the State Youth Services Commission and a summary of accomplishments provided by the State Youth Services Commission, dated March 28, 1983.
71. *Ibid.*
72. The two counties which have full-time staff for their Youth Services Commissions are Burlington and Somerset.
73. Letter dated March 22, 1984 sent to all Freeholder Directors and County Executives by Robert N. Wilentz, (Chief Justice of the New Jersey Supreme Court); Irwin I. Kimmelman, (Attorney General for New Jersey); and George J. Albanese, (Commissioner of the New Jersey Department of Human Services).
74. New Jersey Department of Corrections, Division of Juvenile Services, Application to the State Law Enforcement Planning Agency for funding to establish a Youth Advocacy Project (dated 1983).
75. N.J. STAT. ANN. 2A:4-3a to -3e.
76. To determine the actual per county allocation of these funds, a formula based upon county population size was utilized. Thus, the actual allocations varied according to the population size of the individual counties.

VI.

- A STATEWIDE AGENDA FOR CHILDREN IS NOT ESTABLISHED ON A REGULAR BASIS TO GUIDE POLICY AND PROGRAM DEVELOPMENT.
- A STATEWIDE INVENTORY OF SERVICES IS NOT MAINTAINED TO PROVIDE A PICTURE OF WHO IS GETTING WHAT SERVICES AT WHAT COST.
- THERE IS NO CLEARINGHOUSE TO FACILITATE COMMUNICATION AMONG THE THREE BRANCHES OF GOVERNMENT AND TO PROVIDE COMMUNITY GROUPS WITH INFORMATION ABOUT PROGRAMS.
- THERE IS NO NEUTRAL ENTITY TO FACILITATE RESOLUTION OF COORDINATION ISSUES AND SERVICE DELIVERY PROBLEMS THAT INVOLVE THE OPERATIONS OF DIFFERENT UNITS OF STATE GOVERNMENT.
- CONSISTENT SUPPORT IS NOT PROVIDED FOR BROAD PREVENTION EFFORTS.
- CONFLICTING POLICIES ARISE ABOUT THE SAME ISSUE.
- CRITICAL NEEDS GO UNMET.
- BROAD COMMUNITY AND PRIVATE SECTOR SUPPORT HAVE NOT BEEN DEVELOPED FOR CHILDREN'S SERVICES.
- PLANNING IS REACTIVE RATHER THAN PROACTIVE.

Princeton Packet

ACTION TO IDENTIFY AND MEET CHILDREN'S NEEDS: A VOICE FOR CHILDREN

State government alone cannot fully address all the needs and problems reported here. It can, however, provide leadership for vigorous public sector, private sector and community action to assure that the most critical needs of New Jersey's children are identified and met on an on-going basis.

But, no mechanism currently exists within state government to assess children's needs from an organizationally neutral perspective, and to serve as a neutral voice for children in the overall planning process. Children's needs are often overlooked or given low priority, and critical needs go unmet despite the efforts of individual state government units. Further, available resources are not consistently coordinated, and broad efforts do not take place to promote the involvement of the private sector in providing community-based preventive services for children.

This Chapter reports the Governor's Committee's recommendation to establish a mechanism to provide a voice for children in the state planning process, facilitate coordination among the agencies serving children, and build cooperative efforts between the public and private sectors.

The state's commitment to its children has, as outlined in Chapter I, been demonstrated by significant new initiatives to establish policies, planning procedures and programs to improve the effectiveness of services for children. However, a strong, neutral voice for children, a voice free from organizational interests, does not currently exist within state government to see that the development of policies, plans and programs for children is guided by:

1) **Evaluation and Needs Assessment** to identify the needs of children and families; assess the adequacy of current provisions to meet the needs; and identify major service delivery problems.
2) **Planning to Set Priorities on a Statewide Level:** for the allocation of resources; to eliminate gaps and duplications in services; and to resolve broad systems problems.
3) **Centralized Support and Technical Assistance to Facilitate Cooperative Efforts** among state departments and between state departments and local groups to develop needed services and eliminate service delivery problems.

Individual state departments have, to varying degrees, instituted these kinds of actions. However, pronounced deficiencies continue to exist in the overall planning and provision of services because no mechanism currently operates to carry out these functions from an organizationally neutral, broad statewide perspective.[1]

NO STATEWIDE AGENDA FOR CHILDREN

Instead, as the Commission on Children's Services also found, each individual state government unit tends to plan and implement services independently in light of the needs viewed as important by the specific unit.[2] And no neutral entity weighs the priorities set by individual units in light of the overall picture of children's needs on a statewide basis so that the most critical needs can be clearly set forth in a statewide mission for children. In fact, a formal statewide agenda specifying goals and objectives for children in light of current assessments has not been available to guide policy formulation and program development.

PROACTIVE PLANNING DOES NOT CONSISTENTLY OCCUR

The absence of a statewide agenda underscores a fundamental flaw in the planning process: proactive planning from a statewide perspective does not consistently occur to address major needs and problems before they become crises. Even when individual departments have taken a proactive approach, their plans have sometimes been overlooked in the overall state planning and budgeting process.

To illustrate: during the planning process for FY '84, the Department of Human Services projected significant increases in referrals to the Division of Youth and Family Services for child abuse and neglect, and, accordingly, requested funding to hire additional staff to handle the referrals. The requested funds were not appropriated. Five months later, as a result of widespread reports of caseworker overload due to the enormous increase in referrals, the Legislature called a special hearing to review the situation which could have been avoided by funding the necessary staff position at the start of the fiscal year.

NO STATEWIDE INVENTORY OF SERVICES

Further, no mechanism operates currently to provide an overview of the children's services system as a whole. A statewide inventory is not maintained on an on-going basis so that planners have a complete picture of existing policies, programs and expenditures. Moreover, there is no ready method to identify overlap and duplication among the more than 26 different state units which provide services for children.[3]

NO PICTURE OF WHO IS GETTING WHAT SERVICES AT WHAT COST

Both policy development and program planning are impeded by the fact that there is no mechanism for data collection and analysis on a statewide basis so that reliable data is available for needs assessments and to track expenditures. Although many different state units conduct some form of data collection, uniform procedures are not used so that it is difficult to share and aggregate data. As the Commission on Children's Services found, the available data does not provide a picture of who is getting what services at what cost.[4]

NO CLEARINGHOUSE TO FACILITATE COMMUNICATION AND COOPERATION

No central clearinghouse exists to provide the three branches of government and the community with up-to-date information about available programs, services and resources. Thus, agencies whose services should be linked together sometimes do not even know about each other's programs. Further, community members and representatives of the corporate sector who are interested in developing programs do not have easy access to information and technical assistance.

NO NEUTRAL ENTITY TO FACILITATE PROBLEM-SOLVING

Although responsibility for serving children and families is spread across many different state units and is carried as well by thousands of local agencies, no single entity has responsibility for identifying coordination problems among different agencies who address the same population or service need. Moreover, there is no **neutral** entity to facilitate resolution of coordination issues and other service delivery problems involving different agencies.

NO BROAD PREVENTION EFFORT

And, while the need for broad-based prevention efforts has become widely recognized, no single entity has been given responsibility for providing statewide leadership to facilitate prevention efforts at the state and local level. Individual agencies have initiated prevention efforts, but these efforts are largely uncoordinated.

These issues would be of little import in a small, narrowly focused system of services. However, the New Jersey system is immensely complex, one composed of categorical programs which tend to focus on a single problem or disability. This arrangement does not lend itself readily to joint planning among agencies or broad coordination efforts to address the needs of children from a wholistic perspective. Nor does it facilitate cooperative efforts to deal with complex problems which require the intervention of a mix of different agencies.[8]

RESULTANT DEFICIENCIES

Within this context, numerous inefficiencies and inequalities arise and continue unabated, often for extended periods of time and at great cost to both the taxpayers and children of New Jersey. The Governor's Committee, in its deliberations, identified many deficiencies in the planning and coordination of services for specific needs which could have been avoided by an on-going statewide planning effort on behalf of children:

New Jersey Department of Human Services

1. **Statewide Policies Are Not Developed to Harmonize Efforts on Complex Issues, and Conflicting Policies Arise About the Same Issue.** To illustrate: substance abuse is a complex problem which at least six different state departments have some responsibility for addressing. As discussed in the Substance Abuse section in Chapter V of this report, no common strategy has been developed to integrate and maximize the resources of different agencies in dealing with the problem. Even when staffs of different departments have cooperatively developed action plans, administrative support and/or fiscal support has not been provided to implement the plans. In fact, although a statewide Drug and Alcohol Task Force developed recommendations in 1979 for the implementation of prevention and treatment strategies for a broad-based effort to deal with this problem, many of the recommendations have not been funded or fully implemented. Further, conflicting laws and administrative regulations have evolved, so that there are wide variations among agencies and within communities in addressing the issue.

Similar patterns of widely divergent policies and programs affect the state's response to other complex problems which require the involvement of a broad mix of different state and local agencies. These patterns are obvious in the state's response to, inter alia, troubled youth who become involved with the Juvenile Justice system, the increasing problem of adolescent pregnancy, school discipline problems, and health care problems among children. In each of the areas, piecemeal and contradictory approaches have resulted in a fragmented response to the needs of children.

2. **Critical Needs Go Unmet.** Lead poisoning, which causes serious neurological problems and can result in mental retardation or death, has long been recognized as a major cause of childhood illness in New Jersey. But, for years very minimal state funding has been allocated to address the problem and instead federal funds have been relied upon to establish a series of limited screening programs that can reach less than 30 percent of the very young children who are at risk of this devastating problem.

Substance abuse is another largely neglected problem. Despite the increasing prevalence of substance abuse among the state's young people, very little priority has been placed on establishing comprehensive prevention and treatment programs.

Since as early as 1909, state correctional facilities have been required to receive severely disturbed youth who require psychiatric services. Over the years, such youth have lingered in these facilities without proper services because other agencies would not serve them and alternative programs were not developed. These youth, some of whom pose an on-going risk to themselves and/or the community, do not receive the rehabilitative services necessary to assure that they can function in the community when they are released from the correctional facilities.

3. Available Services Supported by Federal Matching Funds Are Under-Utilized. To illustrate: children who are enrolled in the Medicaid program which provides basic health care coverage for needy families and children, are eligible for Early Periodic, Screening, Diagnosis and Treatment (EPSDT) services to prevent serious and chronic health problems. However, although EPSDT has been shown to be highly cost-effective, less than 11 percent of New Jersey's eligible children were screened in 1983.

4. Reliance Continues to Be Placed on Costly, Institutional Care Although Cheaper, More Effective Alternatives Can Be Provided. This pattern is apparent in the state's patterns of funding programs for youth adjudicated delinquent. While institutional care costs nearly double that for small, alternative programs tailored to the needs of the youth, the vast majority of state funds for correctional services continue to be used for institutional care and the state has been slow to provide funds for the development of alternatives.

5. Coordination Problems Are Apparent in the Delivery of A Wide Range of Services, including health care, services for troubled youth involved with the Juvenile Justice system, and social services for children and families at the county level. In each of these broad service categories, a mix of agencies has responsibility for serving children. But, timely and efficient coordination of services does not routinely occur to provide the mix of required services for either individual clients or population groups.

6. Broad Community and Private Sector Support Have Not Been Developed For Children's Services. While there is strong public interest in the needs of New Jersey's children, there is also limited understanding of what can be done to improve the lot of children in this state. Broad-based efforts have not taken place to show the public what New Jersey children need and how those needs can be met.

Much can be done to show the public and individual communities how existing resources can be utilized to better meet the needs of children. Further, based upon the numerous inquiries received by the Governor's Committee, there is substantial untapped interest and capability on the part of the private sector for innovative privately supported initiatives on behalf of children.

PROBLEMS NOT UNIQUE TO NEW JERSEY

These shortcomings are not unique to New Jersey. Through a survey of other states, the Governor's Committee learned that the kinds of deficiencies which affect New Jersey's provision of services for children are common, especially in states where the children's services system is complex and requires the interplay of many different state and local agencies.

BROAD MECHANISMS IN ALMOST EVERY OTHER STATE

In fact, almost every other state in the nation has established at least one on-going mechanism to address these kinds of deficiencies from a broad, statewide perspective **and** to see that children's needs are not overlooked in the planning process. More than one-third of the states have special Legislative Committees to guide the overall development of policies and priorities for children's services. Altogether, there are 27 such committees, with some states having a committee for each chamber of the Legislature.

In 32 states, non-legislative mechanisms have been established either by executive order or legislation. The most common model is the Governor's Commission, Council or Office of Children, and 22 states have such bodies placed either within the Governor's Office itself or in another executive branch unit. Some are located within state planning and budget agencies, while others work with all three branches of government so that there is involvement of the Legislature and the Judiciary in the planning effort on behalf of children.

At least 8 states have Advisory Councils or Boards which work directly with the lead social services agency in planning services for children. And, two states have Offices for Children that are freestanding.

The members of all of these Commissions, Councils and Boards are appointed by the governor. In some cases, the members include a mix of citizens and representatives of state departments while in others the membership is limited to state department officials.

While most of these mechanisms are funded primarily through the state budget, some also receive federal funds. Further, some of the mechanisms have begun to seek private sources of funding.[6]

FUNCTIONS AND IMPACT OF BROAD MECHANISMS

The functions of the mechanisms established by other states vary as do their budgets and staffing levels. Generally, they include (see attached chart):

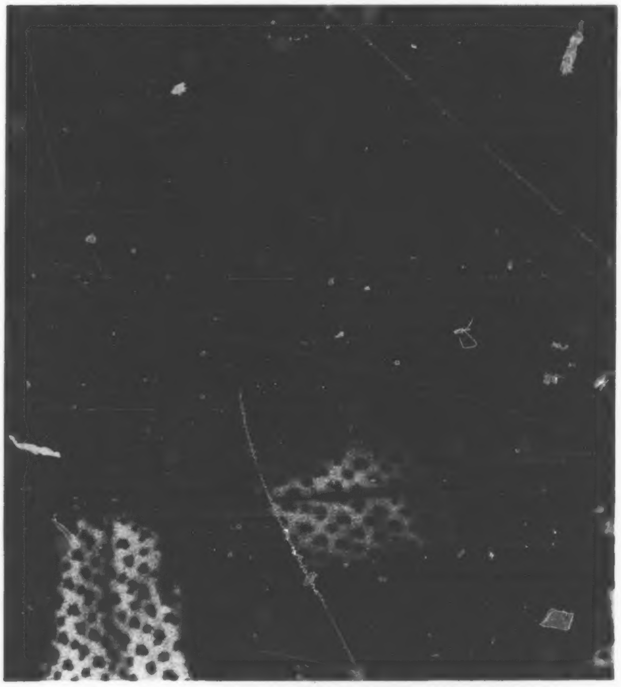
1) Information Gathering, Including Data Collection/Analysis and Research
2) Preparation of Needs Assessment
3) Formulation of State Goals and Objectives for Children's Services
4) Participation in the State Budget Planning Process
5) Preparation and Review of Legislation and Administration Policies Affecting Children
6) Facilitating Inter-Departmental Committees and Task Forces Established to Develop Policies/Programs and Address Service Delivery Issues
7) Clearinghouse/Public Information Activities to Maintain An Inventory of Services and Disseminate Information to Public Officials and Community Groups
8) Provision of Technical Assistance to Community Groups and the Corporate Sector for Voluntary Projects[7]

While the overall achievements of these state units vary, five factors have been reported to influence the range and level of effectiveness of the mechanisms:

1) Role in the State Budget Planning Process—

Those mechanisms which have a direct role in the state budget planning process throughout the planning cycle report the greatest level of success in affecting policy decisions regarding children.

2) **Membership Composition**—Those groups which include representatives of the community report greater success in establishing cooperative coordination efforts among state departments as well as between state and local agencies. They are also more effective in stimulating corporate sector involvement in projects for children.
3) **Location in State Government**—Those units which are housed independently of service providing agencies report more ability to facilitate inter-departmental coordination efforts. Perceived as being neutral entities, these units are better able to play a role of mediator between sparring state units and to bring about the resolution of inter-departmental conflicts.
4) **Reporting Responsibilities**—Those units which report exclusively to the Executive branch report limited effect upon the Legislative and Judicial branch policies regarding services for children. Those with broad reporting responsibilities have been more successful in facilitating the elimination of conflicting policies, and in bringing about agreement from all three branches on specific policies and funding questions.
5) **Relationship to the Governor**—This was identified as the single most important factor. Where the Governor has a demonstrated commitment to the work of the mechanism and uses it to keep abreast of critical children's services issues, the units have been able to be far more effective in influencing state policy as well as developing community and private sector support for children's services.[8]



BENEFITS TO STATE GOVERNMENT, THE PUBLIC AND CHILDREN

Among the mechanisms, there are wide variations in the extent and scope of activities, in part because of differences in mandates and resources. Reported benefits to state government, the public and children include:

1) **Increased integration of laws and policies** affecting children so that conflicting policies do not dissipate resources.
2) **Provision of proactive statewide plans** for services based upon needs assessments and trend analysis for use by the Executive, Legislative and Judicial branches. In some states, this has brought about greater agreement among the three branches in setting priorities for services.
3) **Elimination of duplications and overlaps** in specific service areas so that resources are better utilized.
4) **Provision of data** to give state planners a realistic picture of the total services inventory and state efforts on behalf of children.
5) **Identification of critical service gaps** and systems problems **and** facilitation of inter-departmental efforts on the issues.
6) **Increased communication** among state government units so that they have a better understanding of each other's roles, resources, and limitations. This has served as a basis for cooperative efforts among the state units.
7) **Greater involvement of community** members and the corporate sector in developing and funding programs for children.
8) **Increased awareness of children's needs and children's services,** both within state government and at the community level.[9]

Clearly the experience of other states shows that a neutral mechanism serving as a voice for children in the overall state planning process can be a highly effective tool to bring about improvements in the planning, provision and coordination of programs for children. To a limited extent, the Governor's Committee has functioned in this capacity and from that limited context has served to stimulate cooperative planning among state departments on specific issues.

However, what is needed is a permanent mechanism which contains those features identified by other states as important for effectiveness, and has the resources to meet its mandate. Accordingly, the Committee has prepared a recommendation for the development of such a mechanism to act on behalf of New Jersey's children.

RECOMMENDED ACTIONS

I. ESTABLISH GOVERNOR'S COMMISSION FOR CHILDREN AND YOUTH

A. The state should establish a "Governor's Commission for Children and Youth" to promote the development, provision and coordination of

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those services necessary to strengthen families and assure every child the opportunity to develop to her/his full potential.

B. The Commission should be designed to involve both community members and public officials in:

- **Evaluation and Needs Assessment** to identify the needs of children and families; assess the adequacy of current provisions to meet the needs; and to identify major service delivery problems
- **Planning to Set Priorities on a Statewide Level** for: allocation of resources for children; action to eliminate service gaps and duplications in services; and action to resolve broad systems problems
- **Providing Centralized Support and Technical Assistance to Facilitate Cooperative Efforts** among state departments **and** between state departments and local groups to develop needed services and eliminate service delivery problems

C. The Commission should also address the needs of youth and should be required to foster a broad range of prevention efforts aimed at positive youth development.

II. ENABLING LEGISLATION

The Commission should be established by bi-partisan legislation with a clause requiring a review of the effectiveness of the mechanism following its first five years of operation. This will assure the continuity of the mechanism while at the same time provide formal review and modification if necessary. The enabling legislation should mandate the following structure, functions and responsibilities:

A. **Membership:** Citizen-chaired group jointly appointed by the Governor and the Legislature. The Commission should include a minimum of 15 public members knowledgeable of children's issues and representative of the different population groups within the state. **The Commission should also include the Commissioners of the Departments of Community Affairs, Corrections, Education, Health, Human Services, Labor, and the Public Advocate. Further, the Chief Justice of the Supreme Court should be invited to sit on the Commission. Additionally, the membership should include the Director of the Office of Management and Budget and representatives of both the Senate and the Assembly. The Commission may also request that other state government coordinating committees/councils appoint representatives to sit ex-officio on the Commission and its sub-committees.**

B. **Mandated Scope:** The mandate should enable the Commission to evaluate children's needs and to assist with the planning and coordination of a broad range of services including but not limited to: Health, Education, Social Services, Juvenile Justice, Mental Health, Youth Employment, Early Childhood Development, and Economic Security. The mandate should also authorize the Commission to undertake activities to facilitate a broad range of prevention efforts to foster positive youth development.

C. **Location in State Government:** Established as a separate entity, functioning apart from any state department unit which provides services for children. The mandate should require the Commission to carry out its responsibilities from a neutral framework, not bound by the priorities of any single state agency.

D. **Reporting Responsibilities:** Required to work with **and** report to the Governor, the Legislature and the Judiciary.

E. **Functions, Responsibilities and Authority:** To carry out its role in evaluating needs, setting priorities for action and facilitating cooperative efforts, the Commission's mandated functions and responsibilities should include:

1. **Functions to:**
   - Develop, on an annual basis, **a statewide agenda for children** specifying goals and objectives to guide priority selection and resource allocation.
   - Maintain **a mechanism for data collection and analysis** on a statewide basis to provide data for needs assessments and planning. **This mechanism shall include the statistical data reported annually by all other advisory and coordinating bodies established by either executive order or legislation to address issues affecting children.**
   - Maintain **an overview of the children's services system as a whole,** with an up-to-date inventory of programs, **services, number of persons served, and expenditures.**
   - **Facilitate communication and cooperation among the many different agencies and community groups who**

are interested and providing services for children.

- **Improve procedures for evaluating children's needs** and planning services for children, thereby reducing gaps/duplications in services.
- **Facilitate coordination** among state departments **and** between state and local agencies (county and municipal).
- **Foster increased awareness** of children's needs and critical children's services issues.
- **Facilitate broad prevention efforts** at the state and local level to foster positive youth development.
- **Stimulate increased private sector/community involvement** in planning **and** supporting services for children.

2. **Required to:**
   - Establish and **maintain an information system** that cuts across program and department boundaries to gather data required for: a statewide inventory of services; a "picture" of persons served; needs assessments; and reporting of actual expenditures.
   - On an annual basis, **prepare recommendations** for the Office of Management and Budget and the Legislature for state budget priorities for children. Provide additional recommendations as needed during the overall budget process.
   - **Maintain a "clearinghouse"** to provide the three branches of state government and the community with information on available programs, services and resources. This "clearinghouse" shall also include an inventory of innovative approaches to foster positive youth development.
   - **Advise the Governor** of coordination problems amongst the state departments, propose methods to resolve them, and facilitate planning groups to address specific coordination issues.
   - **Cooperate with public and private agencies** in the development of programs and services for children.
   - **Annually prepare an evaluation of the needs of New Jersey's children, and report to the Governor, the Legislature and the Judiciary** on the status of children and children's services. This report shall include the Commission's recommendations for a statewide agenda for children.
3. **Authorized to:**
   - **Hold public hearings** to gather information about children's needs and service issues.
   - **Conduct studies** on specific issues affecting children.
   - Obtain and **review the annual plans** and budgets of the state departments, and assist in the development of the annual budgets.
   - **Convene meetings** among state officials and between state officials and community members to formulate recommendations to address specific unmet needs and/or to resolve service delivery problems.
   - **Establish such sub-committees and ad hoc groups as are required** to improve the planning and coordination of services for children.
   - **Provide technical assistance** to support the efforts of other state and local bodies involved in the planning and coordination of services for children.
   - Take all actions necessary and proper to carry out the provisions of the enabling legislation.
   - Seek grant funding from private foundations and the federal government for research and other activities.

F. **Resources and Funding:** Provide staff who have a broad knowledge of children's services issues and direct experience in the planning, provision and coordination of services within the state government framework. Staff should also have skills in policy analysis, planning, research, data collection/analysis; public information/community relations; and prevention efforts.

Resources should be provided for the design and operation of a statewide information system. Provision should also be made for reasonable expenses connected with the work of the Commission, including costs for basic office equipment and travel costs incurred by Commission members in the course of their official duties.

Funding should be provided on an annual basis by a separate line appropriation specifically earmarked for the work of the Commission.

Attachment 6.1

Identified Components of Existing State Offices/Commissions for Children

PLANNING AND RESEARCH	SUPPORT OF EXECUTIVE ACTION
1. Collects and maintains data on state expenditures and on the characteristics of children served 2. Prepares analyses of data to show how the state's money is being spent and on whom 3. Reviews the plans and budgets of state agencies to . . . determine whether there are areas where programs might be merged and coordinated to reduce costs . . . identify duplications in services . . . determine whether critical service gaps are addressed 4. Facilitates meetings between community members and state officials to gather information on service needs and to obtain community input for proposed plans	1. Regularly meets with the Governor's Office of Policy and Planning and with Cabinet members to advise of critical service-planning issues and to assist with plans to eliminate inefficiencies in service delivery 2. Prepares analyses of the impact of proposed federal policies and legislation 3. Obtains background information on specific issues under review 4. Prepares comments on proposed policies 5. Facilitates meetings among different state agencies to address interdepartmental coordination issues 6. Serves as a state government representative to county and municipal officials who require technical assistance in program development 7. Serves as the executive branch's ombudsman on behalf of children 8. Advises the executive branch of the concerns of local officials and community members
CLEARINGHOUSE	**ASSISTANCE TO THE LEGISLATURE**
1. Promotes public understanding of ways to improve services for children by publicizing effective programs through presentations to the media and community groups and publishing papers on issues 2. Maintains an inventory of public and private programs, including innovative public-private partnership projects that can serve as models for other communities 3. Serves as an information center for community members who need information on program models and on issues in children's services. Refers interested citizens to model programs and to sources for technical assistance in program development 4. Holds public hearings to gather information on issues in children's services 5. Organizes conferences, seminars, and training programs for community members and for service providers to promote awareness of issues in children's services 6. Disseminates information on legislative developments to community members	1. Gathers public input on children's services issues and summarizes this input for the legislature 2. Assists the legislature with planning hearings on issues in children's services 3. Reviews, tracks, and monitors public laws and proposed legislation to . . . assess impact on children and families . . . determine whether policies will foster duplications in services 4. Assists legislators in obtaining background information on specific issues in children's services that are before the legislature 5. Gathers model legislation from other states and assists the legislature in drafting legislation to address specific issues 6. Prepares testimony for legislative hearings 7. Reviews federal policies and proposed legislation and prepares analyses of their impact for the New Jersey legislature

NOTES

1. This issue was identified by all the Sub-Committees of the Governor's Committee on Children's Services Planning as a broad systems problem affecting many different service categories. See also: R. Alexandra Larson and Carol Kasabach, *Linking Policy with Need* (Trenton, NJ: New Jersey Commission on Children's Services, 1982), chpt. IV.
2. Larson and Kasabach, *Linking Policy with Need,* chpt. IV.
3. *Ibid.* This finding of the Commission on Children's Services also was apparent to the Governor's Committee on Children's Services Planning.
4. *Ibid.*
5. *Ibid.*
6. The information reported here was derived from both the Governor's Committee on Children's Services Planning survey of other states and a survey conducted by the Children's Defense Fund, *State Executive Offices and Advisory Commission on Children and Youth* (Washington, DC: 1984).
7. *Ibid.*
8. *Ibid.*
9. *Ibid.*